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DIGEST OF DISCUSSION OF SUBJECTS OF SPECIAL INTEREST

INDIVIDUAL LIFE AND HEALTH INSURANCE

Individual Health

A. In view of rapidly rising hospital expenses, what is being done to bring medical care insurance up to date and thus expand the sales of coverage to persons not now adequately covered? What underwriting and policy form problems arise, and how are they solved?

B. What sales, underwriting, and policy form approaches are being employed in updating loss-of-time coverages? What steps are being taken to avoid overinsurance?

New York Regional Meeting

MR. EDWIN L. BARTLESON: It is difficult to realize how rapidly and how high hospital expenses have risen unless one is in the business or has recently had a personal claim. Fifteen years ago the Prudential first started selling individual hospital expense policies with daily room and board benefits ranging from $5 to $15. The average sale then provided a benefit of between $7 and $8. Today our benefit range is $15–$50, and there are very few areas in which $15 can be considered adequate minimum coverage. Semiprivate room and board charges have reached $45 or more in several communities. Nevertheless, it is difficult to get people to buy adequate coverage—our average sale last year was for only $22 daily benefit.

We encourage existing policyholders with inadequate coverage to change to new, larger policies. We give a premium allowance on the change which has the approximate effect of retaining the original-issue-age advantage for the previous coverage. We also agree that any new impairment waiver will apply only to the increase in coverage.

Another way in which we are endeavoring to increase coverage is to sell a policy whose only benefit is a flat $10, $15, or $20 daily while hospital-confined. This does not solve the problem, of course, where the ancillary benefits of the existing coverage are much too small, but it does reduce the over-all inadequacy, and the simple benefit makes for a simple sales presentation. We are selling a fair number of these, and a recent sample showed that nearly one-half of the sales were to supplement our own individual policies.

One of the better ways to bring coverage up to date is to superimpose major medical coverage on existing basic coverage. Like a number of other companies, we sell a major medical with a minimum deductible which is increased at claim time so as not to overlap with other benefits.

While I have no firsthand knowledge, I understand that there are companies giving contractual rights to increase policy benefits at stated intervals or upon the occurrence of stated events, such as moving to an area with higher rates.

MR. WILLIAM C. BROWN: The Guardian major medical product is perhaps rather more subject to obsolescence than that of some other companies. We have a co-ordinated deductible, no coinsurance, but certain inside limits. The inside limit that is most easily out of date is that relating to hospital room and board, where the amount is $30. We are just now introducing a modification to this policy which will change the room and board limit from $30 to $40 and at the same time will change the benefit limit for illness from $20,000 to $50,000.

This involves a minor drafting problem. In our particular policy these benefits are shown on a summary page. Our solution is to have different figures on a new summary page without any other change in the contract. This is a partial solution for new sales. We will make this so-called high option available to existing policies on our current form, which has been in effect for only about a year, but it does not do anything for previous issues.

We have always had the practice, though, of permitting conversions freely, subject to evidence of insurability, so that that would be the manner in which the older policies could be updated to some extent.

MR. ALBERT A. BINGHAM: At the Mutual of New York, inside limits for room and board and surgical procedures have been included in all medical care policies, including major medical. We have major medical coverage with room and board limits as low as $20 per day. In the hospital field, limits can be as low as $8–$10 a day. While providing safeguards against the effect of rising medical care costs, these limits emphasize the necessity of our making available limits which are realistic.

We are able to increase room and board and surgical table amounts on existing major medical and hospital and surgical policies as part of a policy change program. This practice does not cause any significant underwriting problems. We use a regular nonmedical application and underwrite the increase on a new-business basis, taking into account, of course, the amount of increase and our experience with the applicant.

Our real problem in setting up a policy change program involved the payment of dividends which we express as a percentage of premiums. It was necessary to program our dividend calculation so as to provide that no dividends would be payable at least during the first two years with respect to that portion of the premium applicable to the increase in benefits.

The dividend rate which we apply to the increase in premium after two years is equal to the rate which then applies to the original premium. In view of our increasing dividend scales, this practice tends to overstate the amount of the dividends, but we feel any other approach would require costly refinements that cannot be justified. Offsetting factors are some savings in renewal commissions and the expectation of better-than-average persistency from changed policies.

Special forms were required to implement the policy-change program:

1. A simplified request form for use with the regular nonmedical portion of our application.
2. A policy premium rider designed to reflect the new total premium for the policy.
3. A policy change rider which specifies the effective date of the change, introduces the contestable period for the benefit increase, and specifies the usual thirty-day waiting period for maternity and the six-month waiting period for elective surgery, where appropriate.

We are able to handle cases where changes in insurability now require a waiver or extra premium. If a waiver is required, a special endorsement is stamped on the policy change rider imposing the waiver and limiting its effect to the increase in benefits. Our regular special class rider can be used for extra premiums charged in connection with the new benefit.

We were concerned about the possibility of receiving requests for very minor increases. I suspect that these requests have not materialized because we have a $10 handling charge on all increases.

MR. HENRY J. MARTIN, JR.: New York Life recently introduced a rider addition program for individual health insurance policies. Under this program, the optional benefits available with new issues can also be added to in-force policies on an "attained-age" basis.

At the present time, we have one rider that is available with hospital expense policies issued at ages 18–60 and two that are available with loss-of-time policies. The one available with hospital expense policies provides additional benefits for doctors' visits, private-duty nursing, laboratory services and X-rays, and room, board, and nursing care in a convalescent home. One rider available with loss-of-time policies provides

AD&D coverage; the other provides additional monthly income for total disability due to accident or sickness.

A special $10 fee is charged, which offsets part of the extra expenses in connection with the rider addition. This fee is waived, however, if application is made within six months of the issue date of the basic policy.

The rider premium is based on the attained age, nearest birthday, of each covered person as of the policy anniversary nearest the effective date of the rider. This premium is payable, along with the premium for the basic policy, on the next premium due date.

There is also a lump-sum pro rata premium charge for the rider, covering the period from its effective date to the next premium due date.

The rider is treated as though it is a separate new policy for purposes of calculating commissions and dividends. Commission years are measured from the effective date of the rider, whereas dividend years are measured from the policy anniversary nearest that date.

The rider application must include all persons covered by the basic policy who are eligible for coverage under the rider. However, if one or more of these persons are unacceptable for coverage, any rider issued will exclude such person or persons from coverage.

A person's underwriting class under the rider may differ from his class under the basic policy. Furthermore, the rider may exclude coverage on a person for certain conditions even though such conditions may be covered by the basic policy. If medical evidence of insurability is required, it is to be furnished without expense to the company.

As far as policy forms are concerned, we use the same rider form as the one used with new issues. However, a second form must also be included in order to modify certain policy provisions, such as those having to do with premiums and incontestability. In addition, the second form may exclude persons from coverage under the rider who are covered under the basic policy; it may exclude a specific condition or it may cover the case where the underwriting class under the rider differs from the class under the basic policy.

Our record-keeping system gives us the flexibility that we need by providing trailer records for riders. This enables us to treat the rider as part of the basic policy for billing purposes and as though it were a separate policy for valuation and for commission and dividend calculations.

This rider addition program was developed in order to enable our policy-owners to bring their health insurance coverages up-to-date. As we develop new types of optional benefits in the future, we hope to be able to make them available to owners of in-force policies.

MR. BARTLESON: As I see it, the problem of updating loss-of-time coverage is primarily one of changing from short-term to long-term benefits. The great bulk of Prudential's policies has been sold with only two years' sickness benefits even though the accident loss of time may be for five years or even lifetime. The net value of disability income with a two-year elimination period is too small to make it economical to sell on an individual basis. If, as is frequently the case, the total amount of coverage is inadequate, the best course, probably, is to retain the existing coverage and issue an additional policy with benefits payable for five years or to age 65.

A major proportion of our policies is sold to so-called blue-collar workers. Underwriting caution frequently restricts coverage to only one or two years' maximum benefits in such cases. For four years we have been offering them policies in which benefits are continued at half rate after two years to age 65. When added to the social security disability benefits, this half-benefit affords fairly good long-term coverage. We are gratified that about 20 per cent of our total sales to these occupational classes are for these longer-term benefits. By way of comparison, about 35 per cent of our total sales to white-collar workers have sickness benefits for more than two years.

MR. HARRY WALKER: Since the first of this year the Equitable has been charging against its 60 per cent of earned-income limit for disability income policies an assumed benefit of $200 per month under social security. In order to fill the gap which will thus exist prior to commencement of social security benefits, we have available a supplemental income benefit to provide income for a period of twelve months minus the elimination period. The benefits under this rider may not exceed $200 per month.

We did some preliminary research on a variation of supplemental income that would have provided benefits for a six-month period followed by continuation of income for another six months if the insured had applied for and had been denied social security benefits. Because of the complexities of such a provision, we did not try to develop such a modified benefit.

MRS. ANNA M. RAPPAPORT: Standard Security has a unique definition of total disability in its current loss-of-time policies. This definition is designed to encourage rehabilitation, to provide adequate financial coverage to the insured, and to provide adequate financial protection to the company.

Under our definition, the insured may continue to receive total dis-

ability benefits, even if he changes to a new occupation after two years of total disability. During the first two years of disability, your occupation definition of disability applies.

If the insured changes to a new occupation, his disability benefits will be reduced by 50 per cent of the excess of his earnings over 50 per cent of his total disability benefit. This allows his disability benefits to decrease gradually as his earnings increase. The fact that there is no reduction in disability benefits until the earnings from his new occupation exceed 50 per cent of this disability income serves as an incentive for the disabled man to try to enter a new occupation.

This definition of disability has been very well received by the field force.

New Orleans Regional Meeting

MR. E. PAUL BARNHART: As most of you are all too painfully aware, hospital expenses, particularly room rates, have been rising so fast that a chaotic situation is developing in existing plans of coverage and also in the issue and participation limit tables of carriers using such underwriting controls. Federal Medicare, together with rapid increases in the wage scales of nurses and other hospital personnel, has been the main influence behind these drastic increases.

The ability of a carrier to react promptly to these changes depends upon the construction of its hospital insurance portfolio. Rates calculated directly in terms of plan room limit will require recalculation for the new, larger amounts. However, where rates are expressed per dollar of daily room maximum, an increase in the issue and participation limit may be all that is required. It may not be this simple where the unit rates have reflected averages relating to policy size, costs of miscellaneous hospital benefits, or deductible credits.

The treatment of existing policyholders presents another problem where the coverage rapidly becomes obsolete.

Some possible solutions to these problems include:

1. Utilizing a rider to provide a daily hospital benefit only to supplement a policy providing full hospital expense coverage. The rate for the rider can be expressed per dollar of daily benefit and is a way of attacking the problem where extras do not increase proportionately to room and board charges. As a control, the rider may be limited to not more than 50 per cent of the daily benefit in the basic plan, so as to preclude an insufficient premium on the basic part of the plan.

2. Another way of attacking high costs is through the use of a deductible which has not been very popular in basic hospital coverage. Increasing costs

may dictate that we ardently promote the deductible as the only answer. This approach is almost universal in automobile insurance. The fact that Medicare relies on a deductible should give agents an added argument in persuading prospects to accept it. To me, a deductible, such as $50 or $100, in basic hospital plans appears to be one of the essential ingredients in combating the increasingly prohibitive costs of insurance.

In addition, the insurance industry must redouble its efforts to establish better understanding and co-operation with doctors and hospitals themselves so that a more effective total effort may be applied to the challenging problem of holding medical costs in line.

MR. PAUL C. MOORE: At Southwestern Life we have no program for a general increase or enrichment of hospital benefits. Since we will not issue two hospital policies to the same insured, we handle a request for increase in daily hospital benefits by endorsing the policy to show the new face amount and the new total premium, which is a composite of the original premium and the added amount on current rates.

Because all our hospital policies have a deductible which is a multiple of the daily benefit, the deductible increases as the larger benefits are provided. To avoid this, our field force sometimes adds a major medical policy to the existing hospital coverage, providing better protection from the insured's standpoint at a premium not too different from that for the desired higher daily benefit.

Regarding loss-of-time coverage, we have not had many requests for larger benefits. For these we do require a new application and also a new inspection, if called for by the amount of increase, to see whether the individual is entitled to the new amount by our rules. Because our noncancelable loss-of-time policy has extended insurance, it is more practical to write a new policy for the total amount than to add a rider to an existing policy for a portion of the benefits bearing a later effective date.

MR. BARNHART: In trying to follow the trend in experience under hospital benefits, what I have found to date seems to indicate that room rates have been increasing more rapidly than miscellaneous hospital expense levels. I wonder if there is anyone who has recent statistics which might throw any further light on relative rates of increase in room rates as compared to other hospital services?

MR. MAYNARD I. KAGEN: We do not have statistics, Paul. However, is this not expected in connection with a reallocation of costs?

MR. BARNHART: It is certainly to be expected, and everything that I have seen seems to point to that. However, I thought that someone might possibly have a more concrete picture of this in terms of actual experience costs, maybe within his own company.

MR. THOMAS K. PENNINGTON: Along that line, could this also be influenced by an increased tendency for radiologists and pathologists to bill for their services separately?

MR. BARNHART: It well could. On that score, I might add, many of the carriers are continuing to recognize charges by radiologists and pathologists if these services are performed during hospitalization. Even if billed separately, this is administratively recognized under the miscellaneous hospital benefit.

MR. REUBEN I. JACOBSON: Two forces are tending to increase hospital-room charges at a greater rate than other charges.

The first is increasing salaries and wages for hospital employees. This has been particularly marked in the case of salaries for nurses who are currently obtaining much-delayed recognition. It takes about twenty man-hours to maintain one hospital bed. This means that an increase of 5 cents an hour in wages increases room charges by $1 a day.

The second factor is Medicare. The government insists that all hospital charges be supported by accurate cost-accounting figures. Traditionally, hospitals have subsidized room charges by increasing other charges, such as X-rays and drugs. The realignment of hospital charges will therefore tend to bring about the results that the chairman has observed.

MR. GERALD A. LEVY: A recently published study by the American Hospital Association shows that the costs of hospital room and board rates in 100 metropolitan areas are as follows:

> Private rooms cost from somewhat below $20 to above $40, the average being about $30.
> Semiprivate, two-bed rooms cost $4–$6 less than private rooms.
> Semiprivate, three-bed rooms cost $6–$8 less than private rooms.

These costs have been increasing substantially in recent years. The answer many companies have come up with is an indemnity policy providing benefits of $10–$20 per day. These benefits are sold to supplement a basic hospital policy. The benefits are payable in cash to the policy-

holder. They are designed to add to his regular hospital coverage, filling the gap needed for immediate cash expenditures which the hospital coverage at present does not provide. For example, these could be used for medical expenses which are not fully covered by insurance, such as nursing benefits, drugs, and so forth, or home expenses, such as cost of a housekeeper, baby care, drugs, and so forth.

These policies are sold with a minimum of underwriting requirements. But, a potential danger is that we may be inviting overinsurance if the total available benefits are in excess of about $40 per day.

My discussion on updating loss-of-time coverage focuses on the sales aspect of this question. I believe that there is considerable value to the "programed sale." Through its use we can better integrate with existing coverage, as, for example, with individual or group, with short- or long-term coverages, or with social security, which is generally universal. The programed sale fills the gap, providing the insured with a relatively level benefit over his working lifetime. It better satisfies the insured's needs and avoids overinsurance by eliminating overlapping coverages. It does, however, present actuaries with a challenge—to devise a reasonably simple schedule of premium rates for the many combinations of benefit and elimination periods.

Use of the programed sale presented my company with a practical reinsurance problem of how to coinsure policies with a variety of monthly income changes. We developed "constant risk retention"—a method for determining direct writing company retention limits. By using a special retention table, we determined what percentage of a policy is reinsured. This method of expressing retentions has the desirable advantage of avoiding overreinsurance and also overretention.

Some of the new health riders are an outgrowth of a life insurance counterpart; for example, the guaranteed additional purchase option, which is similar to the life guaranteed insurability option, or the limited term benefit rider, which is similar to a life family income benefit. I examined a number of guaranteed purchase riders. You may be interested in some of the similarities that I observed:

1. They allow from four to six additional loss-of-time purchases, usually available at the attainment of a specific age, as, for example, 25, 28, 31, 35, 37, 40. Some riders also allow for an additional purchase after the occurrence of a specified event, such as marriage or the birth of a child.
2. The additional purchases are only subject to financial underwriting requirements, that is, subject to the company's maximum issue, participation and percentage of income limits effective on the dates that the options are exercised.

3. They usually provide that an additional purchase is for a fixed amount of monthly income; $100 is the most commonly used.
4. Rarely is the guaranteed additional purchase option available to the more hazardous occupational classes below, say, the second or third occupational rating.
5. The opted policy is at the same rating as the original policy, with the same restrictions. However, the opted policy could be on a more liberal basis, if warranted.
6. The rider only covers claims incurred after the option election date.
7. The opted policy benefit period will be no greater than the benefit period of the basic policy, although many riders restrict opted benefits to five years or less.
8. The cost of the option varies by broad groupings of age, elimination period, and benefit period. The annual cost ranges from about $2 to $4.

CHAIRMAN ROBERT K. LAWRENCE: I rather expected that this would be a topic on which there would be a substantial amount of discussion and interest. I know that many companies like my own have recently introduced an additional indemnity benefit which is designed to integrate with social security benefits. At American General, we hope to have our new disability insurance coverages in effect shortly. Our rider providing disability income benefits through the twelfth month of disability really does more than merely integrate with social security. However, we felt that a benefit period for more than the six-month waiting period was necessary to integrate properly with social security benefits.

I know that a number of other companies have designed these riders to provide this integrated benefit. In effect, it starts at the end of a waiting period, just as a basic benefit would, but is payable through the twelfth month only, at which time the benefit drops and continues at the regular policy rate. I would like to know what, if anything, companies are doing in connection with the social security offset. We are taking a very simple approach; social security benefits, regardless of the marital status of the individual or of his family situation, will be regarded as $200 per month. We consider this as additional income or other coverage in establishing our own limit of issue or participation.

MR. EDWIN B. LANCASTER: In answer to your question, Mr. Lawrence, we at Metropolitan follow the same practice apparently that you do, except that we use $160 for social security rather than $200.

MR. BARNHART: I recently made a survey of the earnings limits within the industry, and I found about half of the companies surveyed seemed to fall in one trend and half in another.

The one trend is to establish earnings limits which *indirectly* recognize social security. For example, one company will issue up to 30 per cent of the first $500; then, from $500 to $1,000 the limit is 80 per cent minus $250. Another company follows the rule of 60 per cent minus $100. Still another has a rule of 50 per cent less $50 if the applicant is single, 50 per cent less $100 if he is married, and 50 per cent less $150 if he is married with children.

The other half of the companies still follow more traditional forms of earnings limit tables, but many are beginning to specify that social security will be *deducted* from the earnings limit in various ways. In some cases a direct offset is taken for the actual eligible amount of social security.

Individual Life Underwriting

A. What changes in phraseology of conditional receipts appear to be suggested by recent court decisions? What are the advantages or disadvantages of adopting a conditional receipt which provides interim coverage up to the time of final underwriting action regardless of what the company's final action is as to acceptance at standard rates, acceptance at substandard rates, or declination?

B. In the light of increasing costs of medical examinations, inspection reports, and other types of underwriting information, what changes may be indicated in nonmedical limits and other types of underwriting rules and procedures?

New York Regional Meeting

MR. ROBERT W. WALKER: I believe that to adopt the approach suggested in the second part of this question simply destroys the basic concept on which the whole conditional receipt theory stands. It introduces a completely new approach instead of a solution to the problem. It acknowledges defeat and accepts the proposition that the courts can write our contracts. Perhaps they do write them on occasion, but, if there is validity to the proposition that insurance protection does not start until the risk is accepted by the insurer, and I believe there is, we should not accept any other approach.

It is critical to the industry that the insurer must be the one to underwrite the risk and determine insurability. Should the interim approach be adopted, we would be saying that our agents are underwriting for us for the initial interim period. We believe that our underwriters should do our underwriting for all periods.

Both the California Supreme Court decision, *Ransom* v. *Penn Mutual*, in 1954, and the more recent New Jersey Supreme Court decision, *Allen* v. *Metropolitan*, in 1965, effectively introduce the concept of "interim coverage," whether intended or not by the companies. Neither the merit of the cases nor that of the opinions is to be discussed here. What I do propose to discuss is one company's philosophy on the basic question of when insurance protection should start—a philosophy which, if believed in, tends to obviate any question of providing interim insurance. I also realize all too well that what we intend to provide and what agents tend to suggest is provided may not be quite the same. Not that any misrepresentation is intended, but the colloquial view and the contract language do not always coincide.

What we all should be concerned with is the prepaid application. We at Northwestern Mutual have stressed the prepayment of insurance for many years. Our agents stress it too. Prepayment is rather effective pre-

underwriting. It qualifies the proposed insured or applicant financially, and it is financially qualified people who purchase insurance which persists. The result is satisfactory "not taken" experience—beneficial to the company, to other policy-owners, and to the agent. We also have the benefit of the continuing good effect of this preselection in low lapse or high persistency rates.

Where there is no prepayment, there clearly is no insurance protection. Where there is prepayment, there *may be* insurance protection. *Just what that protection is and when it starts are the open questions.* Probably the agent colloquially says, "Why not be covered by the policy immediately? Give me your check and it is accomplished." It may not be. With the interim insurance concept, it probably would be. With the conditional receipt concept, the insurance would be effective provided that the proposed insured was insurable. It would not be effective otherwise.

Historically, in prepaid cases, the insurance simply started when approved. If death preceded approval, there simply was no protection. This is what "prepaid" then meant. The best that could be said was that the insurance went into effect before it would have if it were not prepaid. Companies then sought to provide, in the prepaid case, that if the case would have been approved, except for the intervening death, the claim would be paid. Actually this is still the intent. This is how the companies want it in general. This is also how the public wants it in general. And this too is how the field wants it.

This is essentially the problem with which the courts have wrestled. They have found the insuring language of the conditional receipts obscure and the insurer's attitude related to it and the claims filed somewhat inconsistent. I have reviewed the facts as described in some of these cases, and at times I too would be inclined to follow the courts. Some of the cases should never have reached the courts. Companies held premiums unduly and at the same time declined to insure. This is patently inconsistent, and unfortunately the result is poor case law.

This brings me back to the first part of the question: What changes in phraseology appear to be suggested? The most important change in phraseology for all of us is to simplify. It is little wonder that the courts rewrite the intent when the intent is so obscure—when, frankly, we do not always understand it or agree upon it ourselves.

To put it another way, the cases point up the necessity of unambiguous language if a conditional receipt is to be interpreted as conditional in fact rather than as a binding receipt. We do not undertake to insure on prepayment. We undertake to issue and define the conditions of issuance. We have no illusions that we have the complete answer.

We believe in the goal that we are attempting to reach. Length and complexity in language seem to have been necessary to reach that goal, and these cases confirm to us that this same length and complexity would probably tend to defeat the goal in the event that litigation follows.

Before one gets into any of this, however, one must be clear in intent. This is perhaps half the battle. Perfection will not come immediately. It must be pursued regularly. Finally, the agency force must have the same understanding that the home office has of the intent. They too must understand it. For, no matter what we may say about intent, language, or limits on agents' powers, we must recognize that any inconsistencies, incongruities, or ambiguities will be construed for the beneficiary.

Frankly, the binder or immediate protection concept is a fire and casualty concept. The protection can start with a phone call and is honored. This concept is perhaps before the courts much more frequently than the conditional life insurance concept. Hence the spillover in the court decisions. They have a point of reference. In every conditional receipt we are considering stating clearly and simply, *in addition to everything else, "This is not a binder."*

We are aware that some companies are providing complete and immediate protection. We believe, however, that this can bring serious problems that outweigh any and all advantages if carried to the ultimate. The problems that I see, at present, are wholly those of antiselection. For example, if each and every company were to accept the immediate protection proposition, any severely impaired life or uninsurable by any underwriting standard could keep himself almost continuously insured through the prepayment route by a never ending list of insurers. In such a state, the pressure on underwriters to speed up the underwriting process would indeed be greater than ever. Underwriting should not be a pressurized function—nor underwriters a "pressure group"—though some may think that both states of affairs exist now. However, the possibilities for increased underwriting pressures developed by this instant insurance approach are real cause for concern. If only for the sake of those of us who are underwriters, we should move cautiously in this area of operations.

In conclusion, may I say that we believe the effort to improve is worthwhile. We do not despair that no matter what we say the courts will order payment. We want to do our own underwriting. We hope that others feel the same way.

MR. FREDERIC P. CHAPMAN: The court cases referred to in this question—particularly the Gaunt case, the Ransom, Grant, and Wood

cases in California, and the Allen case in New Jersey—have certainly raised some difficult questions. After a long and hard study over about a two-year period, we came to the conclusion that it was impossible, under these decisions, to retain the intent of our previous form of conditional receipt. This intent, of course, was to provide coverage beginning on the date of the application—but only if the applicant was insurable on that date.

After considering at least five or six different basic approaches, Metropolitan came up with a new receipt which can almost be called a full binder. It was introduced on October 31, 1966, and provides what we call "temporary insurance" in cases where an amount at least equal to one monthly premium on the policy applied for is paid with the application. This temporary insurance is in force for a clearly defined period while the application is under consideration, regardless of whether the application is eventually approved for the policy applied for, approved for a policy other than that applied for, or even declined.

In nonmedical cases, temporary insurance begins immediately, as soon as the application is signed. In cases where a medical examination is required by our rules (and we currently interpret this as meaning those rules which are stated in our ratebook and hence are readily available to our agent), full temporary insurance coverage does not begin until the medical examination has been completed. In the meantime, however, we provide coverage against accidental death for a period not to exceed thirty days, as we have done for some time in our conditional receipts.

Once begun, temporary insurance continues until coverage becomes effective under the policy applied for, or until a policy other than that applied for is first offered, or until the application is declined—in no event for more than sixty days from the date of the receipt.

The amount of temporary insurance equals the amount of insurance applied for, subject to an over-all maximum of $50,000. The amount applied for includes the initial value of any family income or level term benefit. Moreover, if an accidental death benefit is applied for and if accidental death does in fact occur, that amount is also included in the claim payment.

If the application is declined or if the company's offer of a policy other than that applied for is refused, the receipt provides for a full refund of the advance payment without any charge for the temporary insurance coverage. If the advance payment is the full first premium on the policy applied for and if such policy is issued as applied for, it has been our practice of long standing to treat the policy as in force and to provide no refund of any part of its first premium. Correspondingly, if the advance

payment is at least a monthly premium but less than the full first premium, and if our offer of the policy applied for is refused, our new receipt provides for a temporary insurance charge equal to one monthly premium on the policy applied for, but not in excess of such premium for a policy providing $50,000 of coverage. Under this procedure, the applicant who applies for an annual, semiannual, or quarterly premium policy but pays less than the full premium is treated as consistently as possible with the applicant who applies for a monthly premium policy.

In our belief, the principal advantages of our new receipt are the following: (1) It uses wording which is consistent with recent court decisions and which our lawyers feel will stand up in the courts—even in California and New Jersey. Our new temporary insurance receipt is a complete document in itself, without reference to the terms of any policy. Hence, it avoids the "relating back" concept which has proved so troublesome in the courts, that is, the concept of a policy being in effect prior to the date of the action that puts it in effect. (2) It gives our agent at least a reasonable chance of properly describing the coverage provided. When handing over our new receipt, the agent can merely say, "Now you are covered," in nonmedical cases, and "You'll be covered as soon as you take your medical examination," in medical cases. Under the old conditional receipt, the agent's statement would have to start off with a number of ifs—such as, "If you give the company all the underwriting information it needs" and "If you are insurable according to the company's rules." Not only do these ifs ruin the sales appeal, but they are very difficult for the agent to present so that the real intent can be understood.

Of course, we anticipate certain disadvantages, the big one being the possibility of greater cost. In developing the new receipt, we tried to build in a number of safeguards against a significant increase over what we paid under our prior receipt, such as:

1. Our new receipt specifically provides that there will be no payment of temporary insurance in the event of material misrepresentation in the application.
2. Temporary insurance is not payable for death by suicide.
3. We have the safety provided by maximum limitations—$50,000 in amount and sixty days for the coverage period.
4. In medical cases, delaying the start of temporary insurance until completion of the examination gives protection against deliberate procrastination before submitting to the required exam.
5. In doubtful cases, our field force is instructed to submit a trial application, without any advance payment.
6. If necessary, we can tighten up our underwriting procedures. However, at the moment we are continuing normal procedures except where there are

obvious cases of antiselection or where the facts clearly warrant prompt termination of temporary insurance—for example, where there is a serious medical or other impairment for which we would decline the application.

As to the actual experience, the new receipt has not been in effect long enough to afford a decent test. Figures to date do show a higher cost, but not an alarming one. We will, of course, keep close watch on the number and type of claims to see if adverse experience should develop. But, at the moment, we are cautiously optimistic and hope that we have come up with a new approach which will provide reasonable coverage and prove attractive to applicants for life insurance policies.

MR. STANLEY L. EISNER: The Prudential's new life prepayment practice provides temporary insurance described in the prepayment receipt attached to the application. If the specified conditions are met, the temporary insurance becomes effective as follows, unless the policy is to be dated ahead: (1) nonmedical, insurance effective immediately; (2) medical, insurance begins when medical examination is made (maximum temporary insurance is $100,000). The temporary insurance may be terminated by the company by written notice to the applicant or by rejecting the application.

When a policy is issued other than as applied for, the temporary insurance changes to the amount the prepayment would buy on the issued basis (but not more than the amount issued). The temporary insurance will run until the policy is placed, reported not taken, or the end of the delivery period (thirty-one days), whichever is earlier.

Prepaid applications will not be permitted if, within the previous twelve months, the proposed insured had a heart attack, stroke, cancer, electrocardiogram for a physical complaint, or medication for high blood pressure.

MR. CHAPMAN: Earlier this year, Metropolitan changed its scale of medical fees to a "reasonable and customary" basis; that is, each examiner is authorized to charge a fee for the examination which is in accord with his established scale of charges. At the same time the company indicated that it considered the scale of fees that it had been regularly paying as reasonable. It is too early for us to know how much of an increase in expense will result, but it is our intent to keep a close rein on it, particularly with respect to the examiner who charges fees that we consider exorbitant.

During the past year we raised our nonmedical limits in two respects: (1) for females to take further advantage of favorable female mortality

and (2) for our smaller policies, where we used simplified underwriting and have broad underwriting classes. We could probably have done this as an expense-saving measure without the increased cost of medical examinations.

Our preferred classification starts at $25,000 for male lives, and for this reason we have been reluctant to raise our nonmedical limit above $24,999 at any age.

Metropolitan already underwrites over 90 per cent of its smaller policies—the Metropolitan Series—and over 75 per cent of its larger policies nonmedically. Moreover, we rely on our field representative's report, in place of an inspection report by an outside organization, on a substantial proportion of our policies under $10,000, including those not medically examined. These rather high proportions reflect the kind of business that we write.

We are reluctant, however, at this time to expand further the size of policies underwritten on minimal information, in spite of their popularity with our field men.

MR. DONALD J. VAN KEUREN: I suggest that the problem of keeping medical examination costs in proper relation to premium rates and other underwriting expenses and at the same time making an adequate appraisal of new risks will not be solved by continual expansion of the range of nonmedical insurance.

The demands of the medical profession for higher examination fees spring from a variety of developments and some special difficulties which a doctor associates with life insurance medical examinations: examinations under adverse conditions, broken appointments, and applicants who are not at home when the doctor calls. Some examiners view this attention to essentially healthy persons as a distraction from their preoccupation with the care of the sick.

On the other hand, both lay and medical underwriters are continually concerned about the reliability of the information for which they are paying.

In my opinion, with the exception of bringing some uniformity in the forms used by the various companies, we have gone as far as we should in the direction of simplification of examination forms. We need all the information that we now ask for, and the completion of the medical examination form of the application is facilitated by the checking of boxes and entering of a few figures. There is the danger of making the examination so simple that it appears trivial and not to be taken seriously. Further, I feel that, for the time being at least, our nonmedical limits are

about as high as they should go. The amounts of insurance that we are underwriting on minimal information are quite substantial.

But—most importantly—simplification of forms and increased nonmedical limits do not solve the problem. The clamor for higher fees will continue, the aggravations will continue, and the concern about reliability of information will still be with us.

At Metropolitan we are seeking another solution by searching for a screening test which will pass those who are in essentially good health and refer for further examination by a physician those who have suffered a medical impairment or have a significant medical history. We are looking for test instruments, derived perhaps from the electronic devices now used in hospitals and clinics, which will make objective tests and record the findings for subsequent transmittal to the home office. We believe that these tests and devices can be operated by persons who do not have a broad medical background.

The tests that we tentatively have under consideration are height, weight, blood pressure, a simplified electrocardiogram, pulse, a test of lung function, and urinalysis. There may also be simple tests or observation covering vision, hearing, tremor, lameness, and deformity.

One of the matters under consideration is the extent to which an applicant should be asked to disrobe; this is a material consideration in deciding just what tests may be used and how much information can be expected from the tests. For example, keeping an applicant fully clothed limits the number of electrodes which may be used for electrocardiographic examination. It is highly desirable that there be a precordial lead, but this is not possible unless the electrode can be placed on the bare chest. A greater drawback is the difficulty in obtaining a record of heart sounds. While there has been successful experimentation in recording heart sounds and interpreting the records, the microphones have been applied to the patient's bare torso. I have gained the impression that the interpretation of the tracings by a phonocardiograph must be the work of an expert in the field.

In addition to these problems, which may be thought of as instrumentation, we anticipate a number of other problems, among which are economics and human reactions.

The ages and amounts of insurance for which this screening test would be appropriate will have to be determined by experimentation. One should not rule out the possibility that present nonmedical limits might be lowered. There is no thought that this screening test would displace the examiner; rather, it would handle the cases in the gray area as well as those in which we cannot afford a medical examination at the going

rate. Those who do not pass the screening test would be referred to a medical examiner. It should be noted that the findings would not be used to diagnose or to treat the applicant who may be in poor health. The results would be used only for underwriting classification.

MR. EDWARD G. WENDT, JR.: New York Life recently increased medical examination fees for "complicated" examinations. The company will now pay up to $5 in excess of our regular $10 fee for medical examinations that are particularly time-consuming. All our approved medical examiners were notified individually of this change in practice. They were instructed to submit a separate bill for the additional fee, up to $5, where they believe such an additional fee is warranted by the extent of the examination.

The amount being paid for adult medical examinations prior to the introduction of this new program was $10. During the three-month period that the new program has been in effect, these medical examination fees have been averaging about $10.50. Furthermore, 88 per cent of the fees paid during this period were for exactly $10, and less than 10 per cent were for exactly $15. The four states which had the highest percentage of $15 fees were Montana, Oregon, Kentucky, and Arizona. In California and New York, where most of our medical examinations are made, only slightly over 10 per cent of the fees were exactly $15.

Naturally, we expect the average cost of our medical examinations to increase gradually under this new program. However, by keeping a close check on our medical examiners' charges and by taking action when these charges appear to be out of line, we hope that we will be able to slow down the tempo of increase.

Our current nonmedical limits are $30,000 at ages 0–14; $25,000 at ages 15–30; $15,000 at ages 31–35; and $5,000 at ages 36–40. These limits were introduced less than a year ago, and frankly we do not believe that further increases in New York Life's nonmedical limits are indicated at this time.

The spread between medical and nonmedical mortality was *14* points, based on the 1964–65 intercompany experience in the first fifteen policy years. This compares with only 8 or 9 points in the late 1950's and the early 1960's. Of course, these differences tend to fluctuate from year to year, but the over-all results appear to indicate that nonmedical mortality experience is certainly not improving as related to medical mortality experience. The generally higher nonmedical limits adopted in recent years may be a significant contributing factor to the relatively high nonmedical mortality experience.

In any event, in view of the current differences between medical and nonmedical mortality and the current average cost of our examinations, at the $10–$11 level, there does not seem to be any justification for increasing our company's nonmedical limits at this time.

MR. JOHN G. McLAUGHLIN, JR.: A number of companies are considering action in view of the increased cost of medical examinations and other underwriting information.

The possibility of increasing nonmedical amount limits is under study in several companies. There is no trend toward expanding the nonmedical age limits, however, and this is as it should be. Some have adopted a "short form" medical, designed to fit a $10 examination fee.

Although they are concerned by the expense problem, it is important to point out that in many instances the companies are willing to pay increased prices for the desired quality and service on medical examinations and attending physicians' statements.

The policy-size limits for inspection reports have been increased in many instances. Particularly in the area of inspection reports, any relaxation requires a really honest and hard-boiled appraisal of the agency force. Even if the move makes sense, continuing vigilance is required because of the real danger of attracting a poor grade of business after adopting liberalized inspection-report requirements. We know of one instance where a rather high inspection-report limit was adopted without this agency appraisal. The results were immediate and disastrous. Within a year there were a number of claims, all but one of which would have been headed off at issue with an inspection report. In a few companies the dollar-amount limit at which attending physicians' statements are solicited has been increased.

The recent and continuing increase in average policy size in the industry suggests that at least part of the increased expense of underwriting requirements may be absorbed. However, this source of savings is modified since a good deal of initial underwriting expense, in our opinion, has to be regarded as per thousand expense, at least up to a very large policy size.

A little long-range crystal-ball gazing indicates that increased nonmedical limits may not be a future source of compensation for increased medical examination fees. Specifically, if diagnostic techniques improve markedly, the spread between nonmedical and medical mortality will increase, thus reducing the dollar nonmedical limits, particularly at ages over 30.

There are two important fundamentals to keep in mind when consider-

ing this question of liberalizing required evidence: (1) There is no substitute for a thorough knowledge and understanding of the company's agency force and its capability to do the initial field selection. (2) Increasing average policy size has helped to solve many of the expense problems of the life insurance industry in the last twenty years. However, underwriting expenses tend to vary more on a per thousand basis, rather than per policy, so that increase of size is not too great a help. Thus, an adequate premium must be charged to bear the expense of selecting the quality of business which the company desires to have on its books.

MR. ALTON P. MORTON: Mr. McLaughlin's remarks on one particular stimulate me to make a couple of points.

As Don van Keuren stated, what we need is some effective screening device which will result in savings compared with the present selective procedures, which depend more heavily on medical examinations, inspection reports, and so forth, and yet will produce mortality results at the desired level. I am not sure that we have used to the fullest an obvious screening device—our agency forces.

The feasibility of nonmedical procedures rests on the answers to two problems. The first problem is at what ages and amounts we need to fear the unknown—that is, what the applicant does not know about his physical condition which may bear on insurability. If neither he nor we know of the existence of an impairment, perhaps we, as actuaries, can price the risk for ages and amounts beyond those we are presently using. There is additionally, of course, the problem that an applicant may know something affecting his insurability yet may fail to tell us. The problem exists for both medical and nonmedical underwriting. The second problem concerning the feasibility of nonmedical underwriting is related in part to this difficulty—whether the company's agents can be expected to help find what an applicant may be reluctant to reveal. Will they also faithfully report, using the best of their ability and training, anything further that may be needed in a sound evaluation of each risk?

It is reasoning along these lines that causes us to feel a little less hopeless about nonmedical procedures, perhaps, than the previous speakers. We think we can sharpen up our nonmedical questions and have developed a new and shorter nonmedical application form. We are also going to try to have our agents give us a clearer picture of the extent of their acquaintanceship and personal knowledge of the risk and the extent to which they are willing to go fully on record as recommending the risk. Now, along with such procedures and with a meaningful follow-through so that agents who prove themselves unusually reliable are

more trusted and those who lean the other way are less trusted, we believe that we can do more business nonmedically and save medical and other underwriting expense as well as improve our underwriting and issue time service.

New Orleans Regional Meeting

MR. CHARLES H. CONNOLLY: By way of introduction, I think that the following review of the general problem of conditional receipts might be helpful.

The contract provisions, practices, and problems of the industry are reflected in the substantial number of court decisions involving the conditional or binding receipt operations of various companies. The cases usually involve a situation in which the applicant died after making application and premium settlement but before receipt of a policy and the company declined liability on the ground that no insurance was in force. The cases reflect a wide variation and diversity in the language of the contract forms. However, for practical purposes, the forms can be classified into three general types, as follows:

1. In the most common type the effectiveness of the insurance is conditioned on approval of the application by the company at its home office. In a majority of the cases the courts have no difficulty in applying the test and in finding no insurance to be effective in the absence of approval. In a minority of the cases the insurance was held to be effective on the date of application, usually on the theory that the particular form involved was ambiguous and therefore subject to construction by the court, and the court held that it was the intention of the parties that insurance would be effective from the date of application until the application was formally accepted or rejected. In many of these cases the ambiguity in the contract was perceptible only to the judge and the plaintiff's lawyer.

2. Some companies issue a binding receipt which recites that, if the applicant is insurable under the company's rules at the date of application, the insurance applied for will be effective at that time. This type is rather infrequently employed but has produced a great deal of litigation. It appears that in a majority of cases the jury has posthumously decided the issue of insurability against the company and in favor of the applicant.

3. A very few companies issue a receipt that provides temporary insurance until the company formally accepts or rejects the application, subject to some limitations, such as a maximum amount and minimum and maximum age limits. Under this form the agent in the field can put the company on the risk to the maximum amount stated in the receipt.

Prior to 1961, at the Southwestern we used the approval type of conditional receipt. The principal problem with this approach resulted from

the fact that about three-fourths of our business is issued on either the preauthorized-check or salary-deduction basis while the only valid premium payment required cash. Following investigation of other companies' practices, we adopted the temporary insurance approach with the amount limited to $25,000. Our receipt was generally similar to that used by Western & Southern at the time, but more restrictive in limiting the coverage to causes originating during the period of temporary insurance and excluding suicide. The form was approved in all states in which we operate. However, in 1965 the Texas department disapproved the application in connection with a new policy form on the grounds that we were excluding death from causes originating prior to the date of the application.

After reviewing our position again, we developed our current receipt, which recognizes as a valid settlement of the first premium either cash, a preauthorized-check authorization, or a salary-deduction order. The coverage goes into effect immediately, provided the applicant is an insurable and acceptable risk at the company's standard premium rates and under its current underwriting rules, limits, and standards. The amount of insurance is restricted to that applied for with a maximum of $250,000. Accidental death benefits are limited to $150,000 in all companies. In effect, we have what is normally referred to as an "insurability receipt," but, through the wording, we have tried to bring in our own underwriting to the greatest extent possible.

In closing, I would like to quote from the remarks of Charles D. Stengel of the Prudential who was on a recent panel of the HOLUA. He said, "It is my view that it is impossible to draft an unambiguous receipt form unless the receipt does give immediate unconditional coverage."

MR. DAVID C. DRAKE: Since 1953 Western & Southern has had the temporary coverage type of conditional receipt. In view of the fact that the Metropolitan and Prudential, among others, are adopting this form, there may be some interest in our experience under this binder. Our receipt provides immediate temporary coverage for thirty days or until accepted or rejected by the company, if sooner. The maximum amount is $25,000. Since we do not date back the policy to the date of application unless requested in order to avoid an age change, the temporary coverage is free in most instances. About 90,000 policies a year are taken on the binding receipt basis—about 40 per cent of our regular ordinary business and almost all our MDO applications.

Our experience has been quite satisfactory. Only about 0.5 per cent of our claims occur in the binding receipt period, and we feel that not more

than 7 per cent of these could be successfully avoided under the more traditional form of receipt. This more liberal coverage has cost us about $3,000 a year since 1953 in additional claims which might otherwise have been denied. We think that this modest cost is more than offset by reduced costs of litigation and by improved policyholder relations.

MR. RICHARD A. BURROWS: At Fidelity Mutual we have been discussing changing our conditional receipt to a binding receipt, but no decision has yet been made. The following comments should be considered as my personal observations.

I have little doubt that (1) the buying public believes that advance payment of the premium grants immediate coverage without condition, except perhaps as to suicide and misrepresentation; (2) the sales force, at the least, does not emphasize the stated conditions, which are usually that the prospect be insurable as a standard risk; and (3) the life insurance industry should adopt a binding receipt that grants interim coverage during the period of the underwriting.

The advantages of such a binding receipt are:

1. A positive sales aid that will help to get more money with the application and reduce the "not taken" rate.
2. A reduction in legal-staff time spent fighting probable losing battles.
3. A sharpening of field and home-office underwriting.

Disadvantages are:

1. The possibility of "death bed" applications from agents who are not concerned with the company's interests.
2. Increased claim costs.

MR. LEON D. FORBES: The Lincoln National currently has a conditional receipt of the insurability type. Our legal staff feels that a clearly drafted receipt has a good chance of being enforced. We are currently redrafting our receipt to improve its clarity. In the process, we are considering changing the format. We think that the format ought to be changed to start out with bold-faced warnings to the effect that there will be no coverage unless and until every condition raised in the receipt has been met. This statement should be immediately followed by a list of health conditions.

We also concluded that our agents' instructions should be refurbished, particularly stressing that it is not a good practice to take money and to give a receipt if no coverage under the receipt can go into effect. Another practice which should be discontinued is that of taking an application on a certain date without money and then returning at some later time to take money without rewriting the application.

MR. WAID J. DAVIDSON, JR.: One of our life company clients is a subsidiary dealing mainly through fire and casualty agents. They use the third type of receipt that Charlie Connolly mentioned—that is, immediately going on the risk until such time as they decline it. This works well with the casualty agent because it is their customary practice on other types of insurance. As a control, they follow the practice of screening all applications immediately upon receipt and quickly getting off the risk if there is any hint of a problem in connection with the application. The maximum amount of temporary insurance is $25,000, which limitation has not presented much of a problem because the business comes from fire and casualty people.

MR. WILLIAM M. SNELL: The Northwestern Mutual's conditional receipt does not rely on standard rates. If the person is insurable on any basis with us, then there is coverage proportionate to the premium that was paid. We do not like the interim insurance approach because we think the home office should do the underwriting. We are currently revising our conditional receipt, aiming for greater simplicity, but plan to continue with our proportionate coverage approach.

CHAIRMAN ROBERT K. LAWRENCE: At the American General we recently increased the medical examination fee to $15 and considered seriously liberalizing our nonmedical limits, particularly above age 40. Management decided, however, not to make any immediate change in our nonmedical limits.

MR. CONNOLLY: At the Southwestern, we are reviewing our medical examination fees and anticipate going to $15. Some increase in nonmedical limits might be possible below age 35, but all data available indicate strongly the advisability of only minimal nonmedical limits above age 40.

MR. PHILIP F. FINNEGAN: Up until mid-February the Prudential paid a standard $10 fee for medical examinations. Although we told examiners at that time that we would in the future pay their usual and customary fee, we did not mean just that. Since then, whenever we have received a charge in excess of $15, we have written a letter to the examiner stating that we do not expect to pay more than that amount. We have not had any loss of examiners because of this practice.

A study just completed in our Houston office indicates that our average fee has risen to $11.97 during the first four months under our new practice. In general, city doctors have raised their fees to $15, while those in the smaller towns and rural areas have kept the $10 fee, although I imagine that they will be raising their fees before too long.

Reinsurance

What are the relative advantages of the yearly renewable term, coinsurance, and modified coinsurance forms of reinsurance for

A. Established companies?

B. New companies?

New York Regional Meeting

MR. ROBERT T. JACKSON: For any company, the YRT form, whether participating or not, has the advantage of establishing in advance the approximate cost of reinsurance since the ceding company pays a predetermined select premium for mortality coverage only. It is also normally associated with more liberal recapture terms than other forms. It has the disadvantage of leaving with the ceding company all the surplus drains normally associated with writing business, in addition to the small drain for the cost of the reinsurance.

Since coinsurance is, in effect, a transfer to the reinsurer of a part of the policy, it offers the advantage of transferring to the reinsurer some of the surplus drain in the early years to the extent that the expense allowances paid by the reinsurer cover the actual issue expenses. It will also transfer to the reinsurer some of the risk associated with interest and lapse. Normally recapture is available only after the policy has been in force many years.

In view of these facts, it would seem that the established company, for whom surplus drain will not normally be an important problem, would wish to get YRT reinsurance. If the policy produces a reasonable profit, the coinsurer is going to receive part of that profit, and, in the event of good experience, the amount can be much larger than the ceding company would pay gladly.

The disadvantage of not knowing the actual costs of reinsurance may be offset for a newer company by the need to conserve surplus so that coinsurance is more attractive even at a higher price.

Modified coinsurance usually provides that the ceding company holds the reserves on reinsured business and pays the reinsurer a specified rate of interest on them.

It is a reasonable assumption that any reinsurer expects to cover the costs of doing business and to receive some reward for the risks assumed; he will expect also to receive no less from modified than from regular coinsurance. Therefore, the transfer rate should make little difference, since, with a high rate, the expense allowances will be more generous.

Having decided on coinsurance, should a company seek regular or modified? On the basis of our assumption, the decision should hinge on

whether the ceding company believes that it can invest the reserves more favorably than the reinsurer. Since most small companies' access to the more attractive mortgage and private-placement opportunities is limited, it seems questionable whether modified coinsurance is a desirable form for them to seek.

MR. ARCHIBALD H. McAULAY: I would like to review the historical development of the three forms of reinsurance.

Prior to the depression of the thirties, a number of mutual companies were acting as reinsurers and favored coinsurance. With the depression, many reinsurance contracts were canceled, many reinsurers ceased reinsuring, and there was a switch to modified coinsurance. Some companies were not certain about their solvency and were not prepared to leave substantial coinsurance reserves with other companies which might be even less solvent—thus the switch to modified coinsurance, which is identical with coinsurance except that the asset is maintained under the control of the ceding company. Many mutuals still use the form of coinsurance adopted after the depression.

Since the depression hundreds of stock life companies have been formed. The great majority use the YRT method of reinsurance, although some with surplus insufficient to support new-business growth have used some form of coinsurance.

It is strange that a reinsurer should be financing through coinsurance a new stock company without sufficient surplus for its growth, on one hand, and an established mutual company with more than ample surplus for its growth, on the other hand. In both cases it is reasonable to expect that the reinsurer be paid for its financing services in addition to its charge for risk protection.

The reason usually given for the use of modified coinsurance by mutual companies is that the direct company has to pay regular dividends on reinsured business and must receive the same dividends from the reinsurer irrespective of the reinsurance experience. This is a narrow point of view and may be fallacious. Actual dividends paid can be affected by dividend policy. The cost of coinsurance may be affected substantially by the dividend policy of the ceding company, a factor which may bear no relation to the business reinsured. Coinsurance will cost more at the very time a company is trying to build up its own surplus by a conservative dividend policy. It will cost less if the company feels that everything is going and there is ample surplus and thus is using a liberal dividend policy.

It is not possible for the ceding company or the reinsurer to forecast

on a basis of actuarial considerations what the dividend policy will be ten to twenty years from now on policies being coinsured currently. Neither can tell what the cost will be and whether or not the fluctuations will be substantial as compared with YRT costs.

This objection to coinsurance does not apply, of course, to nonparticipating policies. Stock companies, however, seem to avoid coinsurance and select YRT coverage of the specific hazard concerned, namely, mortality.

MR. JOHN C. WOODDY: The textbook considerations of this topic are covered in the *Study Notes* and in the illustrative solution to question 11 on Part 10I of the 1964 Examinations.

Reinsurance is a commonplace term which defies definition, except the general one of a financial transaction or set of transactions.

Coinsurance probably is the oldest form and the simplest to comprehend. It is readily applicable to individual life insurance, with or without benefits, and to group and health insurance. It may be on an individual-case basis or may consist of a quota share of a specified block of policies.

In a variation of the usual form of coinsurance, the reinsurance is on the same plan as the original policy, but the nominal gross premium rates are nonpar (whether the original policy is par or nonpar) and are established by the reinsurer, as are the nominal commission rates and cash values. A further variation is use of just one plan, say, whole life, regardless of the original policy plan.

YRT or risk premium reinsurance of individual policies is based on the elementary actuarial mathematics underlying the legal reserve system. It provides a rough and ready means of getting reasonably close to the ceding company's true exposure to the risk of loss from mortality while maintaining administrative simplicity.

Modified coinsurance sounds like coinsurance with the reserves held by the principal company. The pattern of payments between ceding company and reinsurer is such, however, that this form might be called risk premium reinsurance on original terms, transacted on a calendar-year basis, and normally characterized by negative premiums in the first year.

Returning now to the variations of coinsurance mentioned, considering the conventional results of modified coinsurance, and giving thought to the potentialities of YRT, we can clearly see that the reinsurance transaction consists of *exchanging one payment or series of payments involving contingencies for another payment or series of payments involving contingencies*. The ceding company pays the reinsurer for the privilege of making the exchange because the contingent payments of which it divests itself have a relatively high probability of being at least inconvenient, at worst

fatal. The inconvenience may consist of adverse claim fluctuations, unnecessarily costly tax consequences, inability to exploit a particular market or type of business without the help of reinsurance, or some other undesirable effect.

New Orleans Regional Meeting

MR. C. DAVID SILLETTO: Yearly renewable term is the simplest way for a company to buy mortality protection. The coverage and the maintenance of the cessions are straightforward and easily understood, as are accounting procedures and proper treatment in the annual statement. This primary advantage of simplicity is important in new companies which may have a shortage of competent technical staff. Very often this simplicity will be the primary consideration in the choice of a form of reinsurance.

When coinsurance is used, the price structure and basic form of the reinsurance parallel the primary insurance. This has several important implications pointing out the advantages of coinsurance of some form. Some of the important ones are:

1. Responsibility for reserves is transferred to the reinsurer, who will carry the reserve or transfer the necessary funds to the reinsured. This is important where establishing the reserves would cause excessive strain for the reinsured.

2. Since it involves assets and reserves, coinsurance is desirable where protection against investment risk is sought. For example, a company may be hesitant about issuing and reinsuring a large single-premium annuity in a particular investment climate.

3. Coinsurance puts the reinsurer in much the same financial position as with direct business. Any inherent persistency risk in a block of business, therefore, will be passed on to the coinsurer.

4. Use of the same price basis for both the direct and reinsurance transactions is important on participating business. With changes in its dividend scale, the reinsured knows reinsurance costs will change accordingly.

5. The underwriting and claim philosophy and practices of the reinsured may have a significant effect on over-all financial results. For example, in health insurance, claim practices can have a significant effect on claim costs. "Preferred risk" underwriting practices on life insurance which will hopefully lead to unusually low mortality costs might be another example. YRT requires the reinsurer to put a price on the risks that it is assuming. This can be difficult in problem areas, and coinsurance provides a desirable solution if it can be assumed that the reinsured has priced the business properly.

In essence, coinsurance is more complicated than YRT, but its complexity makes it more flexible. It should be explored if anything other than pure mortality protection is desired.

The significant difference between coinsurance and modified coinsur-

ance is that of who will establish the reserves and who will possess the assets with which to do so. The choice of method depends on the objective desired. The reinsurer may not be qualified in the reinsured's jurisdiction, so that no credit is allowed to the reinsured for ceded reserves. Here modified coinsurance is almost a necessity to avoid having the reinsured establish the reserves without having the assets to do so. In other situations it may be inconvenient to have a large asset flow between the two companies, so that modified coinsurance may be desired by both. Beyond this, it is merely a question of how badly the reinsured wants to keep the assets.

Modified coinsurance is more complex, both because the reserve transfer requires extra records and the treatment for federal income tax is quite involved. Deciding whether the advantages of keeping the assets justify the complications can be a perplexing problem for new companies. To retain the assets adds to the stature of the company, but the complications are technical and may cause problems in the absence of actuarial staff. The question becomes academic if the reinsurance program does not generate a large asset, as in a program involving term insurance only or in large companies where the ceded reserves are small in relation to total assets.

Recently efforts have been made to increase the flexibility and versatility of YRT without destroying its simplicity. Select and ultimate YRT premiums now are widely available and also are graded by size through use of policy fees. Programs are available to accomplish certain objectives or be appropriate in certain situations. For example, YRT programs with only a symbolic first-year premium seek to achieve the reduction in surplus drain afforded by coinsurance. YRT programs have been developed also for specific use by larger, well-established companies in situations where a very large average cession will result and recapture is not of prime importance. Although no momentous shift in choice of methods has resulted, these developments have caused some movement away from a form of coinsurance toward some form of YRT.

MR. GERALD A. LEVY: Reinsurers offer three main products, each of which is a method of reinsurance. They are YRT, coinsurance, and modified coinsurance. Any advantages depend upon how the direct-writing company favors their special features, that is, how these features satisfy the company's needs. Since no one product likely will satisfy all major needs, there is a choice calling for weighing of the respective features and judging in total which product does the best job.

A new company probably desires to receive from its reinsurer some or

all of the following: protection; special services, such as underwriting assistance; growth power (i.e., asset build-up and ability to recapture); and relief for surplus and from initial expenses. Established companies usually are mainly interested in risk protection and an orderly emergence of earnings. Both new and established companies will be interested in reinsurance costs and administrative expenses.

YRT protects only against the mortality risk; modified coinsurance against mortality and lapse; and coinsurance against mortality lapse and investment. Both forms of coinsurance pay expenses and reduce the expense risk.

The greater protection of the coinsurance forms might be more desirable than YRT if protection were the only element to consider, but YRT has greater growth potential and is simpler to administer.

There are a number of annual-statement differences between the three methods. First, as to emergence of profits, YRT does not reduce the initial statement losses from new business. Both forms of coinsurance transfer any book loss to the reinsurer since he reimburses the direct-writing company for his share of commissions and expenses and also incurs the reserve charge. With the coinsurances, the direct-writing company enjoys a faster emergence of book profits.

Second, the asset build-up and investment income are different under the reinsurance method. Increase in assets is associated with company growth. Under modified coinsurance, assets are transferred to the direct-writing company. In early policy years, when surplus drain is greatest, payments made by the reinsurer in part come from his surplus. Thus, this method gives the most build-up of assets. Under YRT, assets are accumulated after the initial surplus drain is overcome, with only minor amounts of assets going to the reinsurer. Under coinsurance, assets on reinsured business are given to the reinsurer, leaving the least amount of assets with the direct-writing company.

He who holds the assets enjoys the investment income so that, under coinsurance, the reinsurer receives the assets and the income. Under modified coinsurance the direct-writing company has the assets and the income, giving an agreed-upon share of the latter to the reinsurer as part of the reserve adjustment.

The last of the annual-statement differences concerns federal income tax implications. The new company should be aware of its tax position to avoid losing carry-forward tax losses. The emergence of statement profits, build-up of assets, and investment income are all a part of the development of federal income tax. A direct-writing company knowing its tax base could minimize its income taxes by selecting a reinsurance

method that initially reduces taxable income, assuming that deferred taxable income is dollars saved. For example, a company taxed on a gain from operations base could minimize its taxable income by reinsuring under the YRT method which produces the greatest book loss and, therefore, minimizes federal tax. For a company taxed on an investment income base, the gain from operations is not taxed, so that taxes will be lower if the coinsurance method is used since it minimizes assets and taxable investment income.

The new company, in need of substantial immediate gains to offset large carry-forward losses soon to expire, could use a special form of either coinsurance method on an in-force block of business to generate large immediate gains.

Tax implications, however, are only one of several factors to consider before reaching a conclusion about a method of reinsurance.

Reinsurance cost depends on the method of reinsurance. It consists of the total gross profit to the reinsurer, including provision for its expenses plus the direct-writing company's reinsurance administration expenses. YRT is the simplest method and also the least costly to administer for both companies. Modified coinsurance is the most complicated to administer, because it includes special reporting of reserve adjustments and the reinsurer must maintain and administer special valuation records.

New companies usually look to their reinsurance to aid their growth objectives, whereas established companies are not as concerned about this feature. As new companies grow and increase their retentions, they like to recapture reinsured business. The more liberal recapture provisions of YRT are a real advantage in this respect. Modified coinsurance and YRT also generate more assets for the direct-writing company.

MR. THOMAS K. PENNINGTON: In the typical young-company situation, the development of symbolic first-year premium and sharply graded select and ultimate reinsurance rates has substantially eliminated the need for coinsurance within the last few years. The basic reason for coinsurance in these cases was to relieve heavy surplus drain imposed by conventional YRT rates and to allow a young company to compete on the same cost basis as larger companies by sharing the surplus drain of large-term policies with the reinsurer.

Today, coinsurance appears to be usable only as a surplus relief device, with the agreement covering existing blocks of business for the small, young company.

Expenses of Individual Policy Pension Funds

What are the problems involved in making split-funded, individual policy pension funds self-supporting:

A. If the supplementary funds are held by the insurer?
B. If the supplementary funds are held by a separate trustee?
C. If sold by general-agency companies?
D. If sold by companies using the branch-manager system?

New York Regional Meeting

MR. ERNEST J. MOORHEAD: From a financial standpoint for the life company writing pension trust business, there are three problems. These have little relationship to whether the plan is split-funded or not, the auxiliary fund is held by the insurer or not, or the business is sold by a general-agency or a branch-office company. The problems all stem from a single one, namely, the historic practice from which we have moved all too slowly of forcing pension trust business into the straitjacket of a vehicle designed for individual selling.

The three problems are (1) the termination rate, (2) the extra administrative cost compared with nonpension business, and (3) the prevalence of policies for small amounts.

The aggregate termination rate runs at least double that of nonpension business. The early lapse rate may be about the same, but the sharp decrease noted after the first renewal date on nonpension business does not occur on pension business.

The termination rate is a function of each of at least three elements: (*a*) the number of lives in the plan, (*b*) the ages and service periods of the participants, and (*c*) the stability of the industry to which the plan belongs.

The extra administrative cost is the net of two items, (1) the cost of home-office and field-service operations on pension trust business less (2) the saving due to mass collection of premiums. The saving due to simplified underwriting is more than offset by the excess mortality attributable to that simplification and so is not a third factor.

In 1966, New England Life issued 37,000 individual pension trust policies. Of these more than 22,000 were for policy amounts less than $5,000. As many as 12,000 were for amounts less than $2,000. This is a less serious problem than that in the days before computers, but it is still a burden that interferes with the ability to provide an attractive product.

With auxiliary funds, there is presumably a margin from interest earnings that is available if the fund is placed with the insurance com-

pany. If not, an additional expense burden is involved, since the life company is expected to provide valuation and other services. We do not charge a specific fee as some do for these services.

New Orleans Regional Meeting

MR. MARTIN L. ZEFFERT: We have 400 or so of these plans and have resisted payment of commissions on side funds.

We write group insurance and annuities on a rather defensive basis, and agents will occasionally ask to set up a separate plan, change the trust agreement, and write a deposit administration contract.

As a service we have done the actuarial valuations on these contracts whether or not we hold the funds for a long time. It is a simple job on level premium funding. The probability of keeping outside people away is more than worth the effort of the valuation.

We have a couple of prototypes and are working on more. The agent's work is being funneled into the home office. On our prototype there is no question that the company is the administrator of the plan. With a reasonable administrative system, it can be done without too much cost.

H.R. 10 and Tax-sheltered Annuities

What special sales and product approaches seem to be required for

A. The tax-sheltered annuity market?

B. The H.R. 10 market?

New York Regional Meeting

MR. ERNEST J. MOORHEAD: There are six ways in which the product for tax-sheltered annuities and H.R. 10 plans should differ from the normal individual insurance or annuity policy with which we are all familiar. These six ways are:

1. Freedom to change the amount of premium
2. Freedom to change timing of premium payments
3. Flexibility in retirement date
4. Opportunity for terminal funding of part of the retirement benefit
5. Appropriate size of early-year withdrawal benefits
6. Physical separation of insurance and savings elements

1. *Freedom to change the amount of premium.*—This is needed because these plans are on a money-purchase basis; that is, because the policyholder's income will vary and therefore his payments, which are generally a percentage of income, will vary; because these plans may be funded partly through policies and partly through equity accounts; and because, in an H.R. 10 plan, the professional man may wish to pay less than the maximum for himself even though he must pay the required amount for each employee.

2. *Freedom to change timing of premium payments.*—On tax-sheltered annuities, teachers particularly may prefer to spread premiums over nine or ten months and to omit contributions from time to time. On H.R. 10 plans extra payments may be tendered at the end of the year when the amount of taxable income can be estimated more closely.

3. *Flexibility in retirement date.*—This may apply upward or downward in tax-sheltered annuities but, generally, under present requirements, only upward (beyond age 70) on H.R. 10 plans.

4. *Opportunity for terminal funding of part of the retirement benefit.*—The life insurance company must decide how much additional money, beyond the policy cash value, it will accept from outside sources at retirement, what guarantee it is prepared to make now as to the annuity factor to be used, and what, if any, provision it is willing to make for a more attractive conversion rate when the time comes, either as a matter of equity or simply to keep the money from being placed in its own or somebody else's single-premium annuity.

5. *Appropriate size of early-year withdrawal benefits.*—The question how to provide attractive vested benefits upon employee withdrawal in early years arises here also (as discussed under pension plans). If something worthwhile is to be done along these lines, the company must either assume that there will be relatively few withdrawals so that payments of values much higher than asset shares will not cost much, or it must considerably change the pattern of agents' compensation, or it must resort to an arrangement in early policy years for premium refund less a term insurance charge with adjustment in the agents' compensation.

6. *Physical separation of insurance and savings elements.*—There is some advantage to, even though no absolute necessity for, this type of separation. When it can be accomplished, it reduces problems of identifying PS-58 costs for IRS purposes. It also eliminates the need to maintain a fixed ratio between insurance and pension benefits.

MR. HAROLD G. INGRAHAM, JR.: We feel that our more sophisticated agents can profitably sell tax-sheltered annuities (TSA's) to employees of public schools and Section 501(c)(3) organizations, provided that (1) they do not attempt to compete with the carriers offering group annuities on either a fixed- or variable-dollar basis in the large city school systems and (2) they avoid squandering a great deal of time on cases where the school system does not limit the number of participating carriers.

The individual policy approach can have definite merit in the smaller communities. From the agent's standpoint, (1) he has a better chance of controlling the case with his company being designated as sole carrier and (2) prospects encountered through TSA solicitations may enhance his ordinary insurance horizons by serving as centers of influence and sources of referred leads. From the policyholder's standpoint, a case can be made that agents may not provide the same degree of personal service for group annuity certificate-holders as would be the case under individual policy TSA plans.

The sales mix of TSA policies sold by our agents in recent years may be of interest:

1. The average annualized premium per policy has been about $900.
2. Of TSA premiums 70 per cent have been attributable to public school cases.
3. The average issue age of annuities sold is about 50, and the average issue age of contracts providing "incidental life insurance" has been slightly under age 40.
4. About 60 per cent of public school case premiums were attributable to female cases.

5. Less than 5 per cent of sales have involved retirement income type contracts.
6. Our typical participation percentage in the school systems in which we have written business has been about 5 per cent.

The best prospects for public school TSA's seem to be school superintendents, principals, families in which both the husband and wife teach, and spinster teachers with long years of service. The best Section 501(c)(3) organizations seem to be bona fide hospital-staff employees, rabbis and cantors, and higher-salaried employees of nonprofit organizations, such as United Fund groups.

It should be kept in mind that the primary aim of a TSA program—from the participant's standpoint—is to provide the maximum possible retirement income for a given level of premium outlay using pretax dollars. From a competitive standpoint, retirement income per unit of premium is considerably more significant than maturity proceeds. This is because lump-sum distributions under a TSA plan are 100 per cent taxable as ordinary income in the year of distribution—no capital gains treatment is available.

From a TSA marketing standpoint, the following points should be kept in mind:

1. A *flexible deposit feature.*—This is usually desired and can be handled by either using a special rider in conjunction with a level annual premium retirement income or retirement annuity policy or by developing a special policy series. The special rider or policy premium would permit variation of the premium level from year to year within specified limits.

2. *High, early-duration cash values.*—This is a frequently stressed point in competition. While TSA's should be bought for retirement income purposes, teachers nevertheless seem to feel that their TSA contracts should provide early-duration cash values that are reasonably close to the sum of premiums paid.

3. *"Stop-and-go" feature.*—This feature appeals particularly to employees for whom diversions of salary to pay premiums are temporarily suspended because of sabbatical or maternity leaves. Typically, it permits the resumption of full premium payments on behalf of such employees without the necessity of paying the skipped premiums with aftertax dollars.

4. *Waiver of premium disability rider.*—This can be an attractive selling point. A private letter ruling from the IRS Tax Rulings Division has indicated that the cost of waiver coverage would be considered as part of the premium for the annuity.

5. *Invoice billing on a "gap period" basis.*—To accommodate school systems that do not pay their employees during the summer months, it is necessary to co-ordinate premium billing with the incidence of salary reductions by the school.

This topic might well also have been worded, "What special administrative approaches seem to be required for the TSA market?" Whenever a TSA is sold, the effective date of the amended salary agreement, the invoice billing date for the case, and the policy issue date should be properly co-ordinated.

An employer usually requires that the agreement be signed by the participant and filed with him fifteen to thirty days in advance of its effective date so that the amount of salary reduction can be entered into the payroll system. In turn, the agent should date the policy about one month after the agreement's effective date so that adequate funds will be available for premium payments.

Problems also may arise with respect to providing some form of annual report to participants relative to the flexible deposit account, which might show the current cash value and units of paid-up deferred annuity income purchases to date.

Occasionally a sales situation will arise in which a Section 501(c)(3) employer wishes to install a fixed-benefit qualified pension plan using a deposit administration group annuity funding vehicle with the employees contributing to the plan according to an "x per cent of salary" formula. Such employee contributions can be tax-sheltered under Section 403(b) provided that they are made under an annuity contract not qualified under Section 401(a). Use of a group annuity to provide benefits under two kinds of plans will apparently satisfy this criterion as long as the benefits of each plan, as stated in the group annuity contract, are separate and distinguishable—the phrase "each plan" in this sense referring to (1) the allocated tax-sheltered employee contributions accommodated under a rider and (2) the unallocated employer contributions made under the deposit administration contract.

Another approach in the above situation would be to write a non-contributory deposit administration contract and to handle individual employee contributions on a tax-sheltered basis using individual TSA policies. In one such case, the phrase "full-time contract employees" was used in the group annuity and defined those employees who agreed to participate in the TSA program as a condition precedent to coverage under the qualified plan.

There are some doctors who may be deriving income from both private practice and from hospitals as bona fide employees. For such individuals, a TSA plan is far more liberal than an H.R. 10 plan because of a more liberal exclusion allowance, because of the availability of past-service credits, and because certain existing policies can be utilized, in accordance with Revenue Ruling 66-254. However, we have found that most doctors

are now remunerated by hospitals on a fee basis and, hence, do not qualify as bona fide employees.

MR. HARRY WALKER: For the tax-sheltered annuity market the product offered should recognize the treatment accorded investment income earned by insurance companies on "pension plan reserves" under the Internal Revenue Code, as in the case of individual policies issued for qualified pension trust plans. Although the tax credit could be reflected in the premium rate, we reflect it in the life-income-settlement basis and in the dividends.

To meet the special situation of teachers taking sabbatical leaves, we have developed a "stop and go" rider for the retirement annuity form, which in substance permits the reinstatement and redating of the contract by a period equal to the period since lapse, where the contract is in default for six months or more. The reissued contract, for the same amount of premium, will generally have a smaller cash value than the cash value of the original contract at the time of change. To avoid the tax consequences of paying out the difference in cash values, the excess cash value is credited to the reissued contract in the form of a paid-up annuity addition.

A tax-sheltered annuity problem occurs when the salaries of teachers are payable only during nine or ten months of the year. We secure a sufficient remittance during the months that salary is paid to meet the monthly premiums in the two or three months that no salary is paid. These excess payments are held in escrow without any interest credit.

A problem arises with respect to dividend options. Since the tax-sheltered annuity contract is owned by the individual, any interest credited under the dividend deposit option could be considered as reportable income for tax purposes. Accordingly, we offer a dividend additions option under tax-sheltered annuities. This option, in the case of the retirement income insurance form, however, affects the amount to be included as taxable to cover the cost of insurance each year.

For the H.R. 10 market, we make available the same types of contracts under our prototype plans as those for tax-sheltered annuities, except that the deferred annuity is on a special form called "adjustable premium annuity." Under this contract, the premium payments in any year are flexible and may range from $100 to $2,500 or may be skipped entirely without the contract lapsing. A different type of accounting and record-keeping system is required than that for a conventional type of contract. A level commission system is used, to assure a reasonable relationship between the values accruing from the first year's premium and premiums

paid in renewal years. We believe that this feature of the contract is important, as it avoids the inconsistent treatment that would otherwise be accorded the person with high earnings the first year and low earnings the second year, as compared with the person with low earnings the first year and high earnings the second year.

The adjustable premium annuity contract is particularly well suited for the self-employed individual whose income may fluctuate from year to year and who accordingly wants to vary his contribution with his current year's income rather than to rely on a rate of contribution based on the three-year averaging of income prior to issue.

MR. NORMAN C. FORD: My comments will be limited to Part A of this question.

We feel that any federal income tax benefit arising from the preferred position of approved benefit plans should be incorporated in the premium-and-dividend structure as far as is possible to provide the maximum benefit per unit of premium. This is particularly true with respect to retirement annuities, which constitute a large portion of our tax-sheltered annuities.

During the years immediately following the passage of the 1958 tax law, we paid a special income tax credit where applicable immediately after our own federal income tax had been computed and filed. Since this method proved unpopular, most of the credit now is in the rate structure with a small residual amount in the dividends. This latter amount will take care of any small year-to-year fluctuations in the total credit available. On old policies still in force, all the credit is in the policy dividend.

All tax-sheltered annuity contracts must provide that the employer pay the premium. We have found that the only practical way of notifying the premium payer as to the amount and due date of the premium is by some form of invoice billing. This has worked out very satisfactorily and has presented no particular problems.

The remaining approaches have to do with the need for extreme flexibility under tax-sheltered annuities. Not all of the necessary flexibility is easy to attain, and some has not yet been attained at all. These approaches arise generally out of the fact that the employer who is paying the premium usually wants to have some fairly rigid relation between the premium and the employee's salary. This relationship takes two forms—one as to the frequency of the premium payment and the other as to the amount.

With respect to frequency, no great difficulty arises provided that the company is willing to arrange for a premium frequency on all the tax-sheltered annuities issued to employees of one employer, which frequency

is equal to the total number of salary payments made to the employees during the work year. In the case of schools, for example, salaries are usually paid for either eight, nine, ten, or twelve months; and, in order to have a satisfactory product, it is necessary for the company to be willing to accept either eight, nine, ten, or twelve installments of premium rather than the usual annual, semiannual, or quarterly installments. It is usually not very difficult to adapt one's practice to this requirement, but a little problem does arise when, as frequently occurs, a teacher transfers from an employer with one schedule of salary payments to an employer with a different schedule of salary payments. It is also quite possible that, depending on the anniversary of the original policy, there may be skip periods during the contract year; that is, where there are eight, nine, or ten monthly premiums, they will not necessarily be eight, nine, or ten consecutive monthly premiums. This flexibility in the number of premiums during the year, together with the requirement of some skip periods, does introduce some complications which are not found in the usual ordinary policy, but they have not seemed to constitute too great a burden in practice.

The requirement of flexibility in premium amount does present some difficulties. If the prospective annuitant merely wishes to be assured that he can continue to pay the same percentage on any future increases in salary, the problem is relatively easy to accommodate by including a supplemental benefit provision in the basic contract. This provision essentially enables the annuitant to have paid for him at his option an additional premium to that provided under the basic contract. A minimum limit, of course, is established to prevent trifling additional premiums, as well as a maximum limit, to prevent possible future antiselection against the company. A new policy would be issued when this point is reached.

Of course, the most complicated type of arrangement that could be desired by the annuitant and by the employer is one in which the premium paid to the insurance company must be a constant percentage of the monthly salary paid to the employee and in which, for some reason or another, that monthly salary varies from month to month. There is a discouraging number of schoolteachers who augment their regular earnings by supervising dances, doing nonteaching work for the school during the summer, refereeing athletic contests, and performing other extracurricular activities.

MR. CHRISTOPHER H. WAIN: So far we have not developed any special policies for the H.R. 10 market but have concentrated our efforts on a single prototype plan. We feel that the greatest marketing strength

for an insurer lies in taking advantage of the features not available from other funding media, such as three-year income averaging and the continued stable contributions that can be made even though earnings go down, as well as the readily determinable benefits of a level premium plan and the attractive supplementary benefits that can be provided with level premium insurance company contracts. Downward fluctuations in earnings can be handled as change transactions and upward fluctuations through liberal new issue requirements.

New Orleans Regional Meeting

MR. WAID J. DAVIDSON, JR.: Among the problems of tax-sheltered annuities are flexibility in the amount of contributions both up and down and flexibility in systems to accommodate school boards which pay less frequently than twelve times a year. Since varying the premium seems to give our computers indigestion, the solution to both problems is frequently found by doing most of the work manually. One method of maintaining flexibility of contributions is to use a deferred annuity with a variable premium. Another method is to use a single-premium deferred annuity rider attached to the base policy, under which the policyholder can pay whatever he wishes (even nothing) in any particular year after which it is calculated as though it were a single-premium deferred annuity. Regarding the problem of frequency of contributions, some employers will pay the insurance company twelve times a year even though they pay their employees less frequently than that. On the other hand, the amounts can be put into an advanced-premium account and applied only once a year.

The market for H.R. 10 plans did not develop nearly as rapidly as had been anticipated when this market was first available to the insurance industry. The recent changes in the law, eliminating two of the worst features of H.R. 10, have revived the interest of many companies, who now hope for rapid expansion of the market. Selling the product requires a complete sales kit, including IRS forms, an illustration of results, and an explanation of the workings of the law.

An important part of the kit is a prototype plan which has been filed and approved. The agent must have available a deferred annuity contract and retirement income contract for both male and female. He should be prepared for the possibility of flexible contributions and should be aware that dividends must be left to accumulate if the contract is participating. Although the same product can frequently be used for ordinary pension lines, it may be necessary to have some differences. For example, guaranteed issue is unimportant in H.R. 10 sales. Since the product is sold as a savings medium, investment return must always be kept in

mind. The high, early cash values which are so important in individual policy pension trusts are not, however, as important under H.R. 10 sales, since the cash value on the latter cannot be used to reduce the employer's cost.

Another interesting marketing aspect in connection with H.R. 10 is an association of individuals who are eligible for this product. A common trustee is set up for the entire association. The trustee purchases ordinary life policies and administers a side fund. The variable contribution is handled through the side fund, and, in some cases, the trustee handles the billing and remits the premiums to the life insurance company.

MR. THOMAS K. PENNINGTON: There is a great deal of current interest in Keogh plans. We are currently developing about ten prototypes in our organization, which are in various stages from complete approval all the way down to the drafting board. The form that seems to fit the market best is ordinary life with a side fund which can handle flexibility of contributions.

As was pointed out by Mr. Davidson, there has been a substantial increase of interest in this market in the last six months. We now see a substantial number of small companies looking for a product for their farm market or professional market. Both these markets need a more flexible funding mechanism than a level premium retirement income endowment can provide. The amount of insurance coverage seems to be important, and flexibility is needed to handle the ratable and uninsurable risks. In general, we recommend that the insurance company hold the side fund.

MR. DEAN A. WAHLBERG: To meet the problem of the need for flexibility in the amount of contribution, we at Minnesota Mutual Life have designed a special accumulation type of contract. The amount of contribution can vary, but each must be at least $10. As we receive each contribution, we deduct a loading to establish the net contributions which will be accumulated.

The contract guarantees a rate at which these contributions will be accumulated and credits additional rates of interest in accordance with our annual dividend resolution.

The billing, to the employer, consists of updating the previous month's payments and shows the total value for each participant in that firm as well as the amounts which would normally be required for the coming month. If there is a difference or if the amount of contributions changes, the employer merely includes this on the billing form that he sends us for the current month. We have found this plan to be very effective.

MR. E. JAMES MORTON: Although the idea of level loading for tax-sheltered annuity appeals to me, I have found that the sales force does not like it. As a result, we have not been too successful in marketing it. The problem which has arisen with regard to schoolteacher annuities is that of keeping a plan in force when a teacher transfers from a school district in which we are an approved insurer to one in which we are not. The teacher is generally quite disappointed at the relationship between the early nonforfeiture values and the total balance paid. Perhaps there should be some kind of clearinghouse to get these payments to the right insurance company.

CHAIRMAN ROBERT K. LAWRENCE: I agree with Mr. Morton that this is an important problem, which results because many school districts are not interested in making a deduction for a number of different insurance companies. A transfer from one school district to another frequently results in either taking a reduced paid-up annuity or surrendering the contract, which, of course, defeats the purpose of the program.

If a company wishes to offer a contract with a cash value fairly close to the total amount paid in after the first couple of years, commissions must generally be quite low. This can make the contract unattractive to many of your agents. If the agent has good control of the business in a school district with a relatively stable teacher population, the high, early cash value is not as important in the sale. On the other hand, a high, early cash value contract may be essential where competition is involved, particularly with a group product.

Another item of interest to companies that issue nonparticipating insurance is the apparent advantage of participating contracts under a money purchase H.R. 10 plan. Although the lower premium of the nonparticipating contract can be an effective advantage in a fixed-benefit plan, higher amounts of insurance and higher guaranteed income provided by the nonparticipating retirement endowment policy under a money purchase plan may not be as effective when competing with the higher total income, including that produced by dividends, under a participating plan. We have received a number of requests from our field force for a participating retirement endowment policy. This problem does not appear to be as acute in the annuity area.

Pretesting the Market

What methods have been employed in pretesting the marketability of new plans of life and health insurance? What has been the success of these methods?

New York Regional Meeting

MR. EDWIN L. BARTLESON: We have never placed any plan of life or health insurance on the market in limited areas to test its acceptance. It seems unlikely that we shall, as all our field force wants any new product as soon as it is available.

To gauge the probable reaction of the public to new plans, we have tried consumer panels, doorstep interviews, and questionnaires. These have not been very productive. It seems that the nature of insurance marketing is such that the agent takes a dominant role in selling what he, the agent, rather than the client, perceives as the major need.

Accordingly, we are guided by what the sales force sees as salable. Occasionally we gather a small group of leading producers for a one-day conference at the home office. We do the same with small groups of selected field managers. We also rely on our training consultants who are in close touch with our sales force, of which they have recently been successful members.

New Orleans Regional Meeting

MR. CHARLES H. CONNOLLY: Developing a product as a result of the clamor of the agency force is the best pretesting device that I know. At Southwestern Life, we have designed some beautiful contracts in the actuarial department from time to time. One of these was in the ratebook for three years before we discovered the minimal level of sales. Although we thought it was an attractive plan, the agents did not sell it. This points up the need for the actuarial department to keep in close touch with the field, because this is where the need for the product is indicated.

Although we have not done any real pretesting of insurance products, we are trying some in connection with a new-agent's contract. We will let each manager hire, this year, two or three men under this contract. The men must meet certain specifications, the most important of which is that this must be their first job. The contract is fatter than our usual contract from a financing standpoint and not from a commission standpoint.

There is an opportunity to test a new-product idea in connection with the group plan for home-office employees before it is presented as an individual policy product. We have done this with long-term disability insurance and the family deductible under our medical care coverage.

MR. THOMAS K. PENNINGTON: I know of one medium-sized insurance company that was thinking of an interesting solution to the pretesting problem. They were thinking of buying a small company which would then be used to test new products. It would be cheaper to put a new product in the hands of the smaller agency force before it was introduced to the larger one.

CHAIRMAN ROBERT K. LAWRENCE: An area where some companies may have done some pretesting is in connection with the financing of premiums. In the college market, we did some selective selling of a special plan because we were interested in the quality of the business. The policy permits financing of the first premium by note and is sold to college seniors. The second premium is payable in cash on the first policy anniversary date. The note is generally paid off after five years by a pure endowment benefit in the policy. If the note is paid in cash prior to this time, the pure endowment benefit is used to purchase additional insurance. For the first year we did not push this particular product. When we saw the results after one year, we decided that we could safely expand our operations gradually.

Some companies have done a good job in helping medical and dental students finance insurance before they go into practice. I think that some of these companies do some pretesting before making the program generally available.

MR. CONNOLLY: For some time we have been financing three premiums of one plan of insurance for doctors. We recently introduced a contract that will have three pure endowments to pay off the note for the first three premiums. This is a separate contract.

Since we would not want to put this contract into the hands of our college agents or newer agents, we therefore restricted it to those who might already be working in the medical market. We added it only to the portfolio of those agents who currently had a credit balance, and, since so few agents qualified, it made an excellent pretesting device.

MR. EDWIN B. LANCASTER: We have recently employed a pretesting system involving the sale, in three states, of an indemnity hospital room and board rider. This was designed to upgrade the outstanding individual health policies referred to in the discussion of that topic. We were interested in this from two points of view. The first had to do with the market for this upgraded coverage, while the other had to do with the field and

home-office underwriting problems associated with it. In an effort to get a reasonable spread of risk, we made an effort not to get only cases with long claim histories. We felt that our underwriting ought to be somewhat more liberal with respect to outstanding policyholders. The experience seems to be very good. Since testing it in three states, we are going forward on a nation-wide basis.