RECORD OF SOCIETY OF ACTUARIES
1976 VOL. 2 NO. 2

CURRENT GROUP INSURANCE TOPICS

Moderator: TED L. DUNN. Panelists: HOWARD J. BOLNICK, JOHN E. BURNOSKY, STEPHEN L. SMITH.

1. Experience rating problems.
2. Group life problems.
3. Long term disability problems.
4. Association group.
5. Utilization of Health Maintenance Organizations.
6. Reinsurance.

MR. JOHN E. BURNOSKY: There are two major parts to experience rating--premium rates and refunds. They must be in harmony. If they are not, the insurer is not likely to achieve its profit or surplus objectives. Moreover, the insurer's policyholders will quickly become dissatisfied with the unpredictable and irregular impact on them.

Profit results and customer dissatisfaction in recent months indicate that this harmony is not present.

A major cause of this disharmony is the sudden and large changes in the rate of price inflation in medical products and services that are occurring. Perhaps more important than the change itself is the unpredictability of the change. As actuaries, we would have no difficulty setting premium rates if the magnitude and timing of price inflation were known. However, we would probably have difficulty in justifying the premium rates to policyholders who did not anticipate such inflation.

The typical premium rate is comprised of expected claims and expenses including contingencies and profit. For cases eligible for refunds, the premium rate usually also includes a margin, but the margin cannot adequately absorb significant understatements of inflation and utilization deterioration.

Let me explain why, using some actual experience rating case results for my company in 1975. We calculated the amount of experience balance for each case on retention accounting as a percentage of the annual premium for the case. We then determined the mean of these percentage experience balances and the standard deviation about the mean. There were about 100 cases with annual premium of between $1 million and $2 million. The standard deviation for this group was 13.5%.

This large dispersion tells us something about the significant variation of actual results from expected even for cases of this size. The risk inherent in this fluctuation can be provided for in two ways--a contingency charge or a margin in the premium rates. If a contingency charge is used alone, it

probably will be unacceptably large for the policyholder. Usually, therefore, most carriers try to include a margin in their premium rates and seek a balance between it and the contingency charge in order to minimize the latter. The margins needed will be in the range of 5 - 10% for the largest cases and perhaps as large as 12 - 15% for smaller cases handled on a retention accounting basis.

There is no redundancy in these margins to compensate for the inadequate deterioration factor. The sudden change in the rate of inflation in 1974 and 1975 was 10 - 15%. That alone is more than the entire margin for most cases. If the premium rate margin is used as an offset to deterioration, then there must be an increase in the contingency charge assessed and that increase will be substantial where the entire margin is used for deterioration.

These events cause serious questions to be raised about the continued viability of retention accounting for Group Health Insurance as it is practiced today. Something must change. As insurance company actuaries, we must either include an adequate deterioration adjustment in our premium rates on a timely basis or make the needed adjustments in the level of contingency charges. The concept and practice of retention accounting where surplus is refunded and deficits are carried forward to be recovered in the future does not work very well when sudden price changes alone cause experience deficits of as much as 15% during a year.

It is this, as much as anything, that is causing employers and other policyholders to turn to alternative arrangements for funding their Group Health Benefits such as Minimum Premium Plans, Administrative Service Contracts, extended premium deferrals, and others.

On the matter of extended premium deferrals and other arrangements for unfunding claim reserves, how does or should the insurer provide for the financial (investment) risk inherent in these arrangements? The insurer has the liability for the incurred but unpaid claims, but the assets have been loaned back to the policyholders.

It can be reasonably argued that the financial risk is still there even if the unfunding takes a form of admitted assets like due and unpaid premiums. Credit, short term or long term, is being extended to policyholders. In the money markets, part of the price the borrower pays for money is for risk. The risk is usually underwritten and a larger price is paid by the greater risk. The realities of extending credit are not any different when the creditor is an insurer and the debtor is a policyholder.

How should this risk be handled? Can and should the insurer underwrite these policyholder debtors and charge accordingly? Or should it take some other approach like treating all credit risks alike? Whatever the approach, it seems clear that the insurer is undertaking a financial risk and this risk should be reflected by an appropriate charge or through some other reasonable alternative.

And what about the impact of these arrangements on Federal Income Taxes? Assets are being converted into non-yielding assets. For insurers taxed on investment income, this usually means an increase in the tax rate. It is relatively easy to determine this impact. You may be surprised to learn how large an effect it can have. Should this cost be included in the price of the arrangement?

There are other effects as well, like the impact on aggregate rate of investment return for the company, and especially the Group Insurance lines. It is reasonable to assume that cash will flow out during years of high investment return and back in during years with low investment return. The impact on the investment return for the insurer is obvious.

Unless all the risks and costs inherent in the unfunding arrangements are recognized and provided for, the demand will continue to grow. I wonder if insurers can afford to have all or most of their claim reserve liabilities held in the form of unsecured assets due from policyholders.

MR. STEPHEN L. SMITH: The Current Situation - One might categorize the current Group Life competitive situation as chaotic, with the appearance of a rate war. This is especially true for certain selected types of groups. Historically, Group Life premium rates were tied to the New York required first year minimum premiums. These were usually discounted to some degree in renewal years. Some companies using Multiple Employer Trusts and those companies not licensed in New York used premium rate tables which resulted in the equivalent of discounts from the New York minimums.

In the past two years, as the result of the elimination of the New York requirement of a minimum first year rate basis, except for virgin cases, and as a result of industry mortality studies such as that conducted by the Society, companies have lowered rates significantly for specific segments of the Group Life market which have shown better than average experience. However, few, if any, rate increases have occurred in those segments showing worse than average experience. This has resulted in profit declines for the industry as a whole and competitive marketing problems. The companies who have not changed rate bases are under great pressure to reduce rates to keep business on the books knowing this will reduce their profits. Those who have reduced rates have already seen their profits decline.

The current market can be segmented into categories.

The Group Life Only Market - Group life not combined with a medical plan is the most competitive segment of the market because a comparison of companies comes right down to which has the lowest rate. Contractual benefits, service, and agent compensation are almost identical for all companies. There is no other coverage in the picture taking the lion's share of the attention in the quotation. Often, if these cases involve an attractive industry or a fairly flat level of benefits or a high percentage of females or younger employees, then rates may be 20¢ per $1,000 per month and some

have even been less than 10¢. Huge volumes of insurance risk are written for very small premiums. A penny per $1,000 of rate becomes overly important; after all,it is 10% of a 10¢ rate and 5% of a 20¢ rate where in the past with 50¢ to 75¢ life rates it was in the neighborhood of 2% or less of premium.

In this market a great amount of ingenuity has been used to justify rate bases giving discounts to various types of groups, those meeting what appear to be favorable characteristics such as a large volume of insurance, low average age, high female content, favorable industry, etc. As mentioned before, this ingenuity has not reflected itself in higher rates for those cases with less favorable characteristics. This has resulted in a substantial decrease in overall premiums per $1,000 for the Group Life Insurance Industry. The Provident Life and Accident has conducted a study of 32 large group life insurance carriers. These companies had a combined total of $4.2 billion of group life premium for 1974. The average group life premium per $1,000 had declined 12.7% from 1970 to 1974. This is the average of each company's percentage reduction and is not weighted by size. Of the 32 companies, 4 had increases in the average rate, 3 had decreases of less than 5%, 13 had decreases of 6% to 15%, 7 had decreases of 16% to 25%, and 5 had decreases of 26% to 35%. Twenty-five out of 32 companies had decreases of more than 5% and 12 had decreases of more than 15%. This data confirms the overall trend since 1970 which has accelerated more recently into a rather rapid decline in premium rates.

The Group Life Market for Life/Medical Cases - Traditionally,Group Life and Medical have been sold as a package. This package has been experience rated on a combined basis and as long as the "total package" had adequate margins and produced profits the individual adequacy of the separate rates, Life and Medical, was of secondary importance. In this situation the group life rates normally contained the larger contingency and profit margins. Now, in the last two years, along come substantially lower group life rate bases. These create pressures from clients and especially from brokers for lower rates on existing cases as well as new ones. Explanations of the margin and contingency situation and probable need for higher medical rates fall on deaf ears. It is known that lower rates are available in the competitive marketplace. This creates problems with renewal of existing cases and heavy competition for new cases. With respect to both new and transferring cases there is something else occurring in the marketplace because of the availability of very low group life rates. Group Life and Medical cases are being split to the extent possible. For example, the medical coverage and a one times salary or similar schedule go together as one case,and a life only case of,say,one times salary goes out to bid as a separate case. In the non-refund market this results in less premium in total over the one combined package and the kicker for the broker is higher total commission dollars. There is only one loser in these situations, the Group Insurance Industry.

What has been the impact on profits of these new lower group life rates? At

Union Mutual, we have been doing comparative studies of other companies results in group insurance for several years. The companies in our study are similar in size group-insurance-wise. Over the 1970 to 1974 period there has not been a noticeable decline in group life profits as a percentage of premiums. Although we have not completed the 1975 study, I did review the preliminary data and it shows at most a very slight decline. This results because the largest share of business contributing to profits is business that was written prior to the last two years. Also the biggest experience rated cases account for a very large percentage of in-force business and profits. These have changed very little. Although there may be other explanations of the very slight decline in profits from 1970 to 1975, group actuaries at companies which have significantly lowered their rate bases are aware from company studies that business written on these newest lower rate bases is at best marginally profitable. Group actuaries at companies not having lowered rates are having a difficult time maintaining their higher bases in the face of competitive pressures.

Summary - What are the solutions to this problem? We must not let the group life business continue to degenerate into a full scale rate war. We must hold the line where it belongs, that is, rates must be maintained at levels adequate for the risks being taken. Those companies who go far below this point will quickly see their profits erode. If the whole industry gets out of line we will suffer not only profitwise but our already somewhat tarnished image will be rusted again.

MR. HOWARD J. BOLNICK: Actuaries pricing life insurance are blessed with a wealth of information regarding mortality experience and sound explanations for the observed experience. Unfortunately, those of us pricing disability insurance are not so blessed. We have neither thorough disability experience nor satisfactory explanations for the observed experience. But, a review of even the little available data on frequency and severity of chronic permanent and total disability claims is a revealing exercise.

Any attempt to interpret available data has severe limitations. Statistics from various studies are limited by:

- data incompatability, caused by substantial changes in disability benefits between early studies and recent studies, and

- data incompleteness, since no data exists for years between early studies, and there has not been enough time to gather complete statistics on recent studies.

Interpretation of available statistics is further hindered by the effect of the Social Security Disability Insurance Program, economic conditions, and, possible widespread malingering on claims.

With the imperfections of the data base in mind, we will sketch a historical perspective of chronic disability from five published studies trying to uncover trends in frequency and severity. Our sketch is based on benefits with

a six month elimination period so that almost all claims arise from chronic disability, not acute disability. Acute disability has substantially different frequency and severity characteristics which must be separately studied.

Sources of Data - During this century only a few significant studies of chronic disability frequency and severity have been made. Of interest to us are:

Early Studies

- Hunter's Table (1912). Alfred Hunter's study based on experience of three fraternal organizations from before 1910. The disability benefit was for permanent and total disability and waiver of premium under life insurance policies.

- 1926 Disability Study. An Actuarial Society of America study based on intercompany experience from 1917 through 1924. Experience is presented for three definitions of disability. The benefit was for permanent and total disability and waiver of premium under life insurance policies.

- 1952 Disability Study. Society of Actuaries study based on intercompany experience from 1930 through 1950. Experience is presented under five combinations of benefits and definitions of disability. The benefits were for permanent and total disability and waiver of premium under life insurance policies.

Recent Studies

- Society of Actuaries Group Long Term Disability Study. Based on intercompany group long term disability experience from 1962 through 1973. Benefits and underwriting differ substantially from earlier disability studies.

- National Health Survey, "Limitations of Activity and Mobility Due to Chronic Conditions." A household interview survey conducted by the Public Health Service since July 1957. The survey provides information concerning the extent and cause of chronic disability in the general population. Although not specifically insurance data, this is a valuable survey.

Actuarial literature does include other studies of chronic disability which generally support our findings.

Frequency - is the most volatile component of disability claim costs. A comparison of data from the five source studies reveals some unexpected trends.

Comparison of Frequency for the Same Disability Benefit from Early Studies

Chart I compares frequency by attained age for a $10 per month per thousand permanent and total disability benefit. Disability is determined based on the merits of each case following a six month elimination period. This benefit and definition of disability were chosen because they are the only ones for which consistent data was gathered under all three early studies. As shown in Chart I, a substantial increase in frequency occurred over the first half of this century. For example, the frequency at age 45 rose from 1.15 per thousand on Hunter's Table to 1.92 on the 1926 Disability Study, to 4.68 on the 1952 Disability Study. Unfortunately, we have no later experience on the same basis. The same trend is observed in other combinations of benefit and definition of disability common to both the 1926 and 1952 Studies. These studies leave us, then, with the impression of a long term upward trend in frequency.

Recent Trends in Group Long Term Disability Frequency

Let us now examine data from the Group Long Term Disability Study. As shown in Chart II, there appears to be a long term upward trend in frequency, interrupted by severe short term fluctuations. After a six month elimination period, frequency has increased from 2.95 claims per thousand in 1964 to 3.47 claims per thousand in 1973.

An increasing frequency is further verified by data from the Health Interview Survey. This survey has shown a fairly consistent increase in persons reporting chronic disabilities "with a limitation of major activity" or "unable to carry on major activity." The percentage of respondents reporting disabilities in these two classes increased from 7.3% in the July 1957 - June 1958 survey to 8.4% in the July 1965 - June 1966 survey, to 9.6% in the 1972 survey. The "unable to carry on major activity" category alone increased from 2.1% to 3.0% of respondents.

Recent data appears to support our impression of a long term upward trend in frequency.

Short Term Fluctuations in Frequency

Throughout this century, changing economic conditions have affected frequency. As Chart II clearly shows, a significant increase in group long term disability frequency occurred during the 1969 - 1970 recession.

Chart III affords further evidence of wide swings in frequency in times of changing economic conditions. The 1952 Disability Study collected frequency data for three time periods: 1930 - 1935, 1936 - 1939, and 1946 - 1950. Frequency was substantially higher in the more desperate economic conditions of the 1930's than in the relatively prosperous late 1940's, varying from 4.35 claims per thousand in 1930 - 1935 to 4.01 in 1936 - 1939 to 1.33 in 1946 - 1950 at age 45.

Summary

Over a short time period, most of us are more willing to ascribe increasing frequency to changing economic conditions or over-insurance than to any long term trend. In the proper perspective, though, we must seriously consider the possibility that short term fluctuations in frequency are masking a long term upward trend.

Severity - A review of severity statistics paints a very different picture from our review of frequency statistics. Contrary to expectations, not much data exists supporting either a trend or violent fluctuations in severity.

Comparison of Severity for the Same Disability Benefit from Early Studies

Chart IV compares severity at age 45 for the first ten durations of disability from the three early studies. The data is presented in this form since termination rates per thousand do not vary significantly over a broad range of ages. Particularly in the first five years, there is no discernable trend. First year termination rates vary from 220 per 1000 claims on Hunter's Table to 315 on the 1926 Study to 180 on the 1952 Study. Fifth year termination rates vary from 51 per 1000 claims on Hunter's Table to 87 on the 1926 Study to 86 on the 1952 Study.

Recent Trends in Group Long Term Disability Severity

From data on group disability benefits, we see on Chart V that there is apparently no trend in termination rates. The key point to note, though, is that actual termination rates are running about 70% of those expected based on the 1952 Disability Study. Apparently, group disability benefits have a natural termination level well below the level generated by a permanent and total disability benefit with the same elimination period.

Short Term Fluctuations in Severity

Short term fluctuations in termination rates do occur, but they are considerably milder than fluctuations in frequency. Data from the 1952 Study shows a variation by time period. As a percentage of graduated termination rates for 1930 - 1950, these variations are:

1930 - 1950	100%
1930 - 1935	91%
1935 - 1939	92%
1939 - 1946	106%
1946 - 1950	112%

That is, termination rates were lower during periods of economic stress, but not appreciably so.

Recent data on group disability terminations seem to confirm this observation. The 1969 - 1970 recession is barely visible on Chart V.

Summary

We find neither a deterioration in chronic disability severity nor volatile swings caused by changing economic conditions. But, there is a surprisingly low level of terminations under group benefits as opposed to permanent and total disability benefits. The annual statement impact of termination rates lower than those used in claim reserves is consistent but small underwriting losses which can easily be misinterpreted as a continuing deterioration in severity.

Causes of Disability - Interestingly enough, a substantial change in the causes of disability has taken place. The 1926 Study found that the most prevalent causes of chronic disability were: tuberculosis, insanity, accidents, cancer, and non-cerebral diseases of the nervous system. These five causes accounted for 61% of all disabilities.

The Health Interview Survey, on the other hand, found that the most prevalent causes of chronic disability in 1972 were: heart condition, arthritis and rheumatism, cerebrovascular disease, impairments of the lower extremities, mental and nervous conditions. The more recent five causes accounted for 44% of all disabilities. Only nervous conditions are common to both lists.

Tentative Explanation of Findings - An adequate explanation must clarify the reasons for our long term observations of:

- a long term upward trend in frequency,
- a stable claim severity,

and, our short term observations of:

- a severe short term volatility in frequency,
- a relatively stable short term severity.

The long term observations can be explained by medical improvements. Medical breakthroughs can be broken into two broad categories: those that prevent disease, and those that maintain or cure disease. Preventive improvements will lower frequency. A good example is the prevention of tuberculosis. Tuberculosis, which used to be the primary cause of chronic disability, is no longer even a significant cause of disability. Maintenance improvements, though, will often convert a death claim into a chronic disability claim. A good example is heart disease. Many patients who would have died suddenly now are becoming chronic disability claims during the lengthy recovery period. Heart disease, which was not a significant cause of disability in 1926, is now the primary cause of disability.

A necessary, but unproven, corollary to this theory is that the time a human needs to recover from serious illness appears to depend less on the cause of the illness than would be expected. If different diseases had substantially different recovery periods, observed claim severity would not be

stable as the causes of disability shift.

Short term fluctuation in frequency seems to be explained by changing economic conditions. The difficulty here is in explaining the lack of short term volatility in severity. This can be explained by observing that extra claims caused by poor economic conditions are most likely far less severe than normal. Therefore, the expected worsening of severity on existing claims is offset by less severe new claims.

With enough time and careful preparation of data, our tentative explanations for the observed data can be adequately explored. With the growing importance of disability insurance to the life insurance industry, I feel these studies should be conducted.

CHART I

COMPARISON OF FREQUENCY FOR A $10 PER MONTH
PTD BENEFIT SIX MONTH ELIMINATION PERIOD

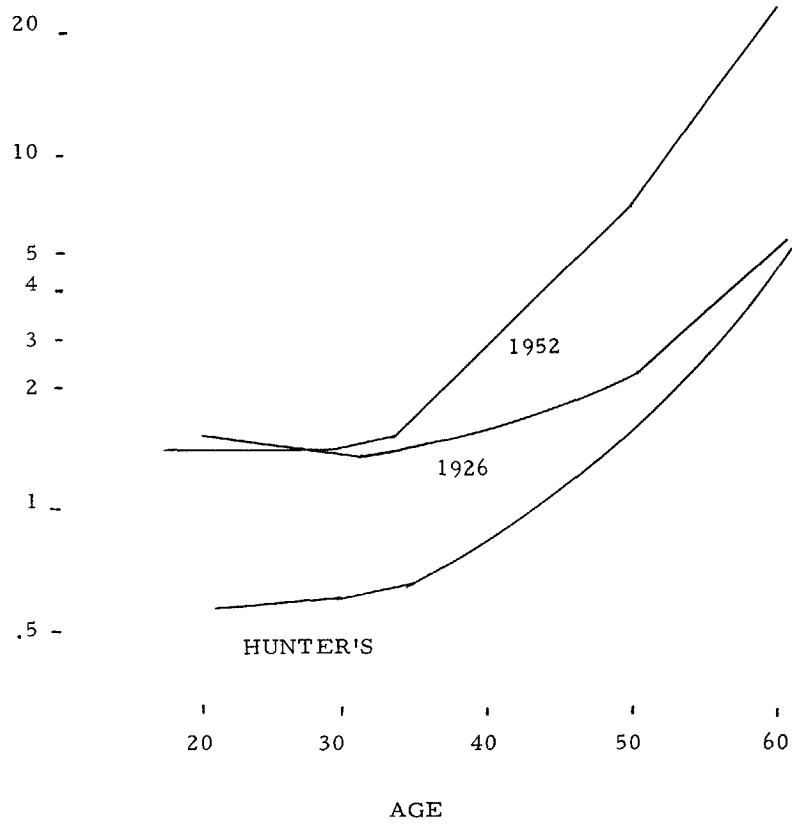


CHART II

S.O.A. GROUP LONG TERM DISABILITY STUDY
SIX MONTH ELIMINATION PERIOD

FREQUENCY

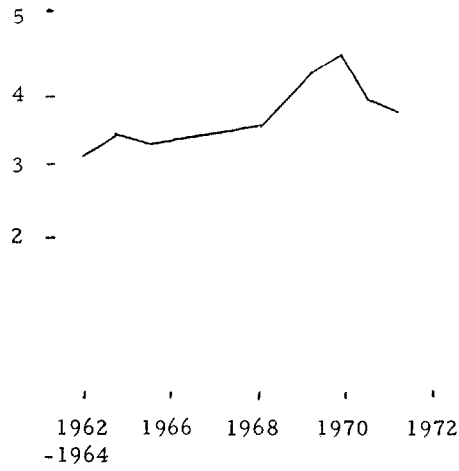


CHART III

COMPARISON OF FREQUENCY FOR A $10 PER MONTH
PTD BENEFIT SIX MONTH ELIMINATION PERIOD

- 1952 S.O.A. STUDY BENEFIT 1 PERIOD 1 (1930-1935)
- 1952 S.O.A. STUDY BENEFIT 1 PERIOD 2 (1936-1939)
- 1952 S.O.A. STUDY BENEFIT 1 PERIOD 4 (1946-1950)

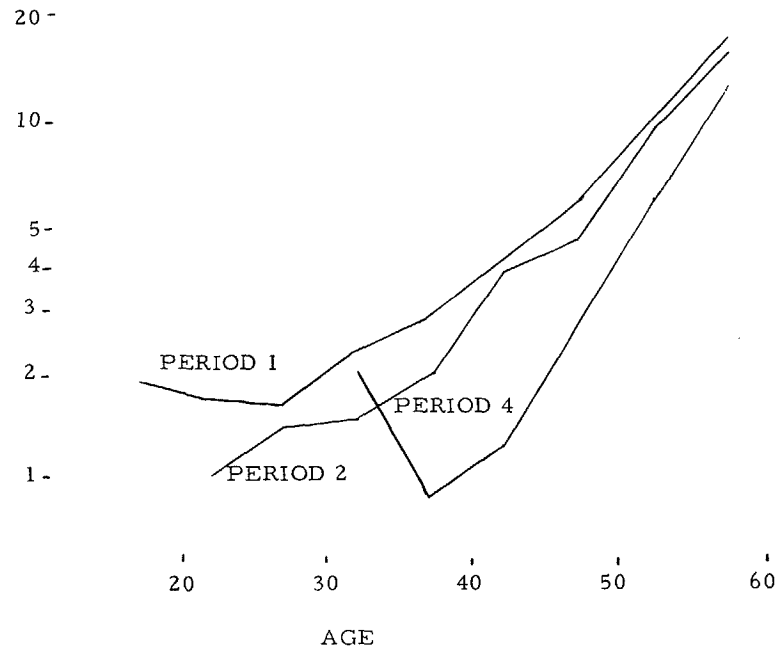


CHART IV

COMPARISON OF TERMINATION RATES FOR A $10 PER MONTH PTD BENEFIT SIX MONTH ELIMINATION PERIOD

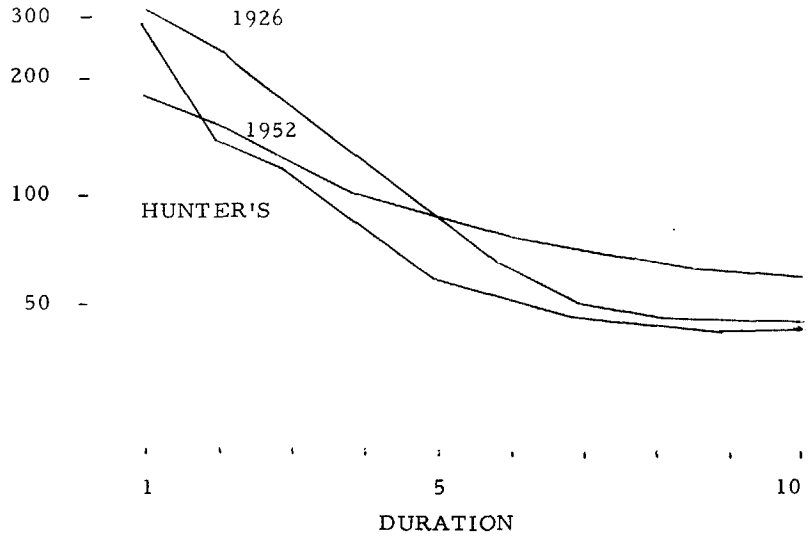
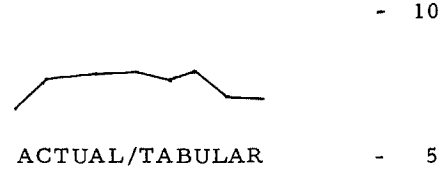


CHART V

S. O. A. GROUP LONG TERM DISABILITY STUDY
SIX MONTH ELIMINATION PERIOD

SEVERITY



MR. TED L. DUNN: The association group market place is a saturated one since most associations already provide some type of group insurance plan for its members. In fact, the Society of Actuaries may be one of the few organizations which does not sponsor some form of optional group insurance coverage for its members.

Many group insurance plans for associations obtain a market penetration on the initial solicitation of only 3% to 4% of the possible number of participants. The results of second and subsequent solicitations usually produce a smaller acceptance rate than the initial solicitation.

Originally, group life and group medical care coverages were made available to association groups. In recent years, disability income coverages have been marketed but the level of experience of this coverage has usually been quite adverse. Currently, cancer coverage and excess major medical coverage are in vogue in this market place. Due to the anticipated substantial selection against the plan, there has been relatively little marketing as yet of group dental coverage for association groups.

The services provided by an insurance company in an HMO situation may range from the full financial backing of the HMO itself to providing assistance in the marketing, administration and risk-bearing areas. The advent of the mandatory dual choice option in the Health Maintenance Organization Act of 1973 injects a new element of uncertainty in this area.

Other than the reinsurance of a particular group case which is done at the direction of the group policyholder, the utilization of group reinsurance is typically because of one of the following two reasons:

1. To shift a liability to the reinsurer which the insurer itself does not wish to carry on its own books.

2. To protect the earnings of the primary insurance carrier from adverse claim fluctuations during a particular accounting period.

Group reinsurance is generally available on group life insurance, AD&D including the employee-pay-all high amount type of AD&D coverage, long term disability coverage, and on group medical care. Particular emphasis is currently being given to high limit major medical reinsurance. An aggregate stop-loss type of reinsurance coverage for a particular group medical care case or a block of group medical business is difficult to place and the price is generally substantial when it is placed.

Many insurance companies are protected by a catastrophe type reinsurance arrangement which may provide for a relatively high deductible as a result of any one accident or may provide that several deaths must occur before any payment will be made. Generally, such arrangements cover the entire group life and group AD&D lines of business and may also include the ordinary life and accidental death benefits for the entire insurance carrier. Some

arrangements also will cover group life, group AD&D, and group medical care expenses arising from any one accident or incident.

MR. WAYNE V. ROBERTS: Would you please name a company which will experience-rate long term disability coverages?

MR. DUNN: Provident Life and Accident is willing to experience-rate long term disability coverages on its larger group policyholders. High monthly amounts of long term disability benefits and all amounts paid after a certain period of time are pooled. This enables the employer to be financially committed to the experience-rated portion of the plan. In this manner, we obtain more cooperation in the handling of claims.

It is not too difficult to determine what portion of a long term disability plan should be experience-rated. For example, consider a group on which the first $30,000 of group life insurance is experience-rated. In terms of long term disability coverages, $30,000 is equivalent to $500 per month for 5 years. If it makes sense to experience rate $30,000 on a sudden payout under group life, it makes just as much sense to experience rate $30,000 of long term disability coverage up to $500 per month for 5 years. Monthly benefits in excess of $500 and all benefit payments after 5 years would be pooled.

MR. BOLNICK: I am surprised to hear that you are in favor of experience-rating long term disability coverages. In effect, the insurance company is left with a 5 year elimination period and that is an unacceptable risk for an insurance company to be taking. There is not a sound basis for rating that kind of coverage.

MR. HARRY L. SUTTON: Mr. Burnosky, you have indicated that a larger margin is needed in the retention charge, in addition to the margin in the premium rate. I have seen quotations from insurance companies for which the retention rate obviously includes a 15% margin even though the previous years claims have been adjusted for trend. The total cost has been divided by 50% to 60% to determine the renewal premium. When employers see this on renewal letters, they react unfavorably. Since it is difficult for insurance companies to justify large margins, there may be a move back to a situation in which no refunds are made and a smaller margin is needed. Perhaps in the future, refunds will not be as important as premium rate levels. Another way to reduce the margin needed would be internal claim pooling of all claims over a certain dollar amount. Many employers with one to two hundred employees are becoming self-insured because they can hire a claim administrator for less money than is required to fund a 15% margin.

The decreasing family size has been a mild offset to the inflationary trend. Do any of the insurance carriers have data to support this hypothesis? In the past insurers have maintained very little data on the number of dependents.

MR. BURNOSKY: I am not aware of any observed change on employees that diverges from changes on dependents. The decrease in maternity rates has been felt on both employee and dependent cost.

MR. CRAIG R. RODBY: I saw a study this year which indicated that employee costs were quite a bit higher than dependent costs. The difference could not be explained from the standpoint of family size. However, there were considerable coordination-of-benefit increases during last year, so that dependent costs were decreasing. The employee costs were increasing because of more working wives.

MR. BOLNICK: We just did a study on coordination of benefits and we have not seen any increase at all.

MR. GEROLD W. FREY: I understand that the new Regulation 32 in New York does not completely release us from restrictions on initial rates on transferred group life coverages. Apparently some companies have not responded to the change in the regulation. Mr. Smith, is there any variation in group life rate reductions according to whether the companies are domiciled in New York or outside New York?

MR. SMITH: The study I referred to earlier does not deal with that point. New York does appear to be willing to accept anything reasonable as a rate base or a formula for use on take-over business.

MR. FREY: Has the New York Insurance Department announced that there were no restrictions or have any companies submitted their rates to the department to get its reaction? It appears that some companies have disregarded the new law and that they have not been challenged by the New York Insurance Department.

MR. SMITH: I am not aware of any new rulings. The intent of the rule seems crystal clear when you read it. You are not supposed to have a large difference between your first year life rates and your renewal life rates, except as results from differences in expense levels, etc.

MR. ROBERTS: I would like to ask two questions concerning group life conversion charges. Studies completed recently by the Standard Insurance Company have indicated that a conversion charge of $115 per $1,000 was appropriate. Does anyone do anything different than using the standard charge of $65 per $1,000? If a group life contract calls for termination of coverage at age 65, does anyone require persons qualifying under the premium waiver for disability benefits to convert their insurance like everyone else instead of continuing coverage until death?

MR. BURNOSKY: At the Aetna we are still charging $65 per $1,000. However, there are companies who are using different levels; in fact, some companies use a graded scale according to age at conversion. With regard to waiver of premium, it is quite common to have the premium waiver

truncated at some age, such as 65 or 70. Some of the major employers are very interested in this approach. It is a middle-of-the-road approach between the more traditional lifetime waiver of premium benefit and the approach of providing the face amount when the employee becomes disabled.

MR. SMITH: I have seen some studies that confirm your overall conversion charge in the neighborhood of $110. With regard to the waiver of premium benefit, some companies reduce the base amount for disabled persons exactly as they would have done for active employees, that is, perhaps a 50% reduction at age 65 or termination of coverage.

MR. DUNN: I believe that there is a paper by Mr. Raymond B. Krieger in the 1971 Transactions of the Society of Actuaries which discusses the net single premium that is needed for a waiver of premium benefit. He discusses five types of benefit provisions: those that cease at age 65, those with immediate reductions, those with graded reductions, those that grade down and then cease, and those with no reductions. Also, an intercompany study on conversion charges was conducted around 1970.

MR. BROCK L. STACKHOUSE: Some of the provinces in Canada now require that the waiver of premium for disability benefit cover persons under 65 whose disability begins after attainment of age 60.

MR. SUTTON: Many of the states are now requiring health insurance conversion privileges. Have the insurance carriers done anything different with regard to making charges for the group health conversion? In the past the cost of the group health conversions was covered by either flat retention charges or by self-supporting rates. Do the conversion rates have to be self-supporting or may retention charges be made?

MR. BOLNICK: We intended that our group health conversion rates be self-supporting. However, the New York Insurance Department indicated that the rates cannot be self-supporting. So we have been forced into a conversion single premium rate, much like we have on group life.

MR. SMITH: The New York Insurance Department had indicated to me that you cannot charge the additional morbidity cost to the converting certificate holder. To get the additional money needed you may use a conversion charge or you may add a little to the margin in your premium rates.

MR. FREY: The National Association of Insurance Commissioners has a committee working on model legislation for group health conversion. It appears that under the provisions of its draft, the insurance companies are not allowed to have self-supporting rates for the group health conversions. The insurance companies may obtain additional compensation by making charges to each policyholder or by increasing the margin in their premium rates.

MR. DUNN: The New York Insurance Department recently proposed a regulation with regard to minimum premium plans. It was a rather unusual

type of regulation in that it provided that if you offered minimum premium to any group policyholder, you had to offer it to all of your group policyholders, apparently regardless of size. There were also rather stringent provisions regarding the fact that minimum premium plans could not be provided on contributory benefits. In addition, the claim reserve had to be fully funded during the first year of the plan, except that up to one third of the claim reserve could be funded through some other means, such as a letter of credit. Does anyone know the status of this proposed regulation?

MR. BURNOSKY: The New York Insurance Department has not released anything since its initial announcement. I believe a number of insurance companies have provided recommendations to the New York Insurance Department on this proposal. The intent of the proposal was to establish funding standards or asset standards for the reserves under minimum premium plans.