TRANSACTIONS OF SOCIETY OF ACTUARIES
1968 VOL. 20 PT. 2 NO. 56 AB

GROUP LIFE AND HEALTH INSURANCE

1. *Permanent Type Insurance Used as a Substitute for Group Term Insurance*
   a) What methods are used to separate the term and permanent elements?
   b) What are the tax implications to the employer and employee (relative to Section 79)?
   c) What are the advantages and disadvantages to both the employer and employee?
   d) What success have companies had in marketing this form of coverage?

Philadelphia Regional Meeting

MR. KENNETH T. CLARK: Permanent-type insurance has been used as a substitute for group term insurance for many years. Where there is a legal limit to group term insurance, as in the so-called 20-40 states, employer-sponsored group permanent insurance has been used when the group term insurance limit has been reached. Single-premium life insurance has been sold in conjunction with group term insurance; the employee contribution, commonly $1 per month per $1,000 of total insurance, is used to purchase paid-up insurance at his attained age; as the paid-up insurance accumulates, the term insurance decreases, so that the total remains constant. During the last two years or so, however, interest has centered around a particular product which is known as "group ordinary life insurance," "group term ordinary insurance," or the like. That is the product about which I shall be talking today, and I shall be calling it by the name by which it seems to be best known—"group ordinary life insurance."

The starting point for group ordinary life insurance is a conventional group term life insurance policy issued to an employer and covering his employees. Each employee is offered the option of converting all or part of his group term insurance to permanent insurance. He may have a choice of plans; the whole life plan, the life paid-up at age 65 plan, and retirement income at age 65 plan are commonly available. The employees who do convert are removed, so to speak, from the term insurance portion of the group policy, but they remain in the group policy. The term insurance which is not converted is priced in the usual way, and I shall not discuss it further. The premium for the insurance which is converted is a level premium. Sometimes the premium is taken out of the company's regular ordinary ratebook; sometimes a special premium scale is developed. This level premium is then paid partly by the employer and partly by the employee. "Who pays what?" is an important question.

We would obviously want to get the same favorable federal income tax treatment in setting up a group ordinary plan that we get with a conventional group term plan—that is, the employer can deduct his contribution from his income but the employee does not have to include the contribution in his income.

It seems fairly clear that the employer will not usually have any trouble in deducting his contribution from his income. His contribution is compensation to the employee and, as such, is an ordinary and necessary business expense. The situation of the employee is not so simple, and I must burden you with a recitation of some pertinent provisions of the Internal Revenue Code.

In general, of course, compensation from an employer is included in the employee's taxable income. This general rule is set forth in Section 61(a) of the Code. Just what compensation is, is covered in the regulations in great detail. In particular, Regulation 1.61-2 says that compensation includes "life insurance premiums paid by the employer on the life of his employee where the proceeds of such insurance are payable to the beneficiary of such employee. . . ." This is the general rule. The regulation then goes on to note that there are exceptions in the case of life insurance provided under qualified pension plans and plans to which Section 79 of the Code applies.

We are not interested in qualified pension plans here. It appears that, if we do *not* want to include the employer's contribution in the employee's income, we need to rely on Section 79. If we look at Section 79, we find the well-known provision that the employer's contribution to "group term life insurance" is not included in the employee's income. How about group ordinary? Is it "group term life insurance"? It is obvious that group ordinary life insurance is not 100 per cent group term life insurance. How, then, do we get the favorable tax treatment for which we are looking?

The answer to this is found in the regulations to Section 79, in particular Regulation 1.79-1(b)(1)(ii). That regulation deals with the situation in which an employee benefit plan containing group term life insurance also contains permanent insurance. The regulation provides in part, the following:

> In the case of a policy which includes permanent insurance, a paid up value, or an equivalent benefit, section 79 shall apply to that portion of the insurance provided thereunder during the taxable year which constitutes group-term life insurance (within the meaning of this subparagraph) only if the policy specifies the portion of the premium which is properly allocable to the group-term insurance and no part of the premium which is not so allocable is paid by the employer.

This regulation gives the answer, although perhaps not as plainly as we should like. It appears that we can get the favorable tax treatment that we are looking for in group ordinary life insurance if (*a*) the policy specifically separates the total premium by saying which portion buys term and which portion buys permanent and (*b*) the employer's contribution is limited to the portion which buys term.

This raises the question of how the total group ordinary premium is separated into the term and permanent portions. There seem to be quite a few ways of doing this.

Since the total premium is constant, we have two basic choices: We can find the term portion and let the permanent portion be the balancing item, or we can find the permanent portion and let the term portion be the balancing item. Suppose we decide to find the term portion. We can say that the term portion of the group ordinary *plan* is the net amount at risk—the amount of insurance minus the cash value. Then we can say that the term portion of the group ordinary *premium* is the value of insurance for the net amount at risk. One way to find this value is to multiply the net amount at risk by the appropriate one-year term insurance premium rate at the employee's attained age. The net amount of risk gets smaller year by year, as the cash value gets bigger, and the one-year term insurance premium gets bigger year by year as the employee gets older. The two partly offset each other; with the whole life plan, the net effect is that the term portion of the premium gets bigger, and eventually it reaches the total group ordinary premium. In the meantime, the permanent portion of the premium gets smaller, since the term and permanent portions must add up to the constant total premium. The question is what happens after the term portion has grown as big as the total premium. Maybe somebody else here can answer that question.

There is another way to find the term portion of the premium. That way is to say that the term portion is the level premium which will pay for the year-by-year net amounts at risk. This is just like finding a level premium for decreasing term insurance. With this way the premium is higher at first than it is the other way, but of course it avoids yearly changes.

So far I have been describing ways of separating the premium by finding the term portion and letting the permanent portion be the balancing item. Now let us try finding the permanent portion and letting the term portion be the balancing item. Now we have to look at the other side of the group ordinary insurance coin. Up to now we have asked ourselves, "What is there in this plan which is term insurance, and what is it worth?" Now we must ask ourselves, "What is there in this plan which is *not* term insurance, and what is it worth?" One answer is that the cash value of group

ordinary insurance is what makes it nonterm insurance. The permanent portion of the group ordinary premium, then, is what buys the cash value. Obviously, there are many ways of getting at that.

One way or another, the premium must be separated. The separation must be set forth in the policy. The employer must be guided by the separation of the total group ordinary premium which is set forth in his policy. If he contributes more than the term portion of the premium, he removes his whole plan from the scope of Section 79, which means that his entire contribution, including the term portion, will be included in the employee's income for tax purposes. This would be very undesirable.

The trouble with all this is that the Internal Revenue Code is like the Bible. We may be sure that it is authoritative, but its meaning in specific situations is not always as plain as we should like. As far as I know, there has been no ruling by the Internal Revenue Service which bears specifically on group ordinary life insurance. We are not certain that this separation system will work. Therefore, there is no certainty, only a strong likelihood, that group ordinary receives the tax treatment which we would like.

So much for taxation. Now I come to the question of what the advantages and disadvantages are to both the employer and employee. The point is controversial, and I suspect that both sides will say their pieces here today. I am going to say mine and run for cover.

I believe that the basic marketing concept of group ordinary is sound and that it can be sold to employer and employee alike. Group ordinary penetrates the middle- and lower-income market. Regular ordinary has not been penetrating that market very well—the debit system is not as strong as it used to be, and nothing has come along to replace it. Group ordinary at least puts the agent in front of a sizable, hard-to-reach market. The greatest weakness of conventional group term insurance is that it cannot practicably be taken away from the job. Group ordinary helps to overcome that weakness. Group ordinary lets the employee acquire permanent insurance without stringent evidence of insurability and with the convenience of payroll deduction. Group ordinary costs him less than regular ordinary because of the employer's subsidy.

A possible disadvantage of group ordinary is that, while it may increase the *quality* of the employee's protection, it does not increase the *quantity* of the employee's protection. We all agree, I am sure, that an increase in the quantity of protection of the public is much needed. In a way, therefore, it is too bad that the permanent insurance in group ordinary is in lieu of the group term insurance rather than along with it. It would be fine if the employee kept his group term and bought regular ordinary in-

surance on the outside. But this is like the buy-term-and-invest-the-difference argument with which we are all familiar. The trouble is that people do not invest the difference. Will the employee buy regular ordinary insurance if he keeps his group term insurance? By and large, the answer has been "no" if you are talking about the lower- and middle-income market. Will the employee buy regular ordinary insurance if he buys group ordinary insurance? I do not know, but at least he is put in touch with an agent. If, as they say, the insurance product is sold and not bought, then anything which brings the agent and customer together is progress.

So much for the employee. There are advantages to the employer too. Group ordinary stabilizes his costs. It is a service to his employees which will be appreciated by them. It enables him to give to the retiring employee protection that the employee can take with him.

There is, of course, the danger that, in buying group ordinary, the employer is complicating the simple, well-understood group term plan. The group ordinary plan may cost more, and it may be hard to discontinue. These are serious problems.

The matter of costs is one which I have not touched upon yet. It is not an easy matter and not as simple as it may at first appear. It certainly is not as simple as many sales-promotion pieces make it out to be. Since the starting point for group ordinary insurance is group term insurance and since the group ordinary replaces the group term, it is inevitable that group ordinary costs will be compared with group term costs. This is very hard to do.

It is very hard to do because the incidence of the group ordinary costs is different from the incidence of the group term costs. Of course, we have the net-cost measurements, which are at least traditional in the regular ordinary insurance business, but these are hardly suitable for comparisons of permanent versus term.

Another reason why it is very hard to compare group ordinary costs with group term costs is that the two are priced so differently. Group ordinary costs are for the most part nonparticipating, and they involve lifetime guarantees. Group term costs are for the most part participating or experience-rated, and they involve very short-term guarantees and frequent repricing.

Still another reason why it is very hard to compare group ordinary costs with group term costs is that the cost is shared by the employer and the employee, and we therefore have to look at each of them separately.

The usual comparison that I have seen compares the cost, before experience rating, of a noncontributory group term plan with the cost of a

group ordinary plan to which the employer makes the maximum contribution. Such a comparison obviously applies to only a limited number of situations.

There has been much criticism of group ordinary on the grounds that it is a bad financial deal for the employer, or the employee, or both of them, that this bad deal results from high acquisition costs, and that these high acquisition costs result largely from overcompensation to the agent. I suppose that some of this criticism is justified and perhaps healthy, because it will bring corrective competitive forces into play. But relatively high acquisition costs appear to be an inherent characteristic of permanent insurance—regular ordinary or group ordinary.

The criticism that I make of group ordinary is that it has not yet realized its full potential. Here we have a distribution system for permanent insurance which combines three of the strongest marketing forces which have been developed by the insurance industry. I mean the agent-to-customer face-to-face contact, sponsorship of the plan by the employer, and mass marketing. I suggest that the rational course is to develop that potential and not to abandon the start which has already been made.

Unless there is some fearful tax upset, it appears that group ordinary life insurance is here to stay. It probably will evolve into a more sophisticated product as time goes on. The pressure from agency sources to enter the market is strong. The choices appear to be to stay out of the market completely, to develop a product which is more or less like the competitive products we see today, or to reach at once toward a more sophisticated form of product.

MR. FREDERICK J. KNOX: Are the assumptions made on a mortality basis?

MR. CLARK: You can use anything which is reasonable, I guess. None has been prescribed. The IRS has not spoken. I believe that some companies are using one of the conventional reserve tables for the mortality basis in splitting the premium.

MR. ROBERT F. RICHARDSON: It seems to me that there would be an advantage to having the full thousand dollars instead of the amount of risk as the portion payable by the employer. Perhaps the best way is to subtract from the whole life premium the term premium on the whole thousand dollars up to, say, age 55. In this manner the employee would get a little more of the insurance paid for by the employer. Is this being done?

MR. CLARK: I think that something very much like that has been done in practice, but I have not heard of that particular arrangement. Certainly it can be defended.

MR. FREDERICK W. CLARK: One of the things that I am concerned about is a customer-relations or public-relations aspect of the product. I would be interested in hearing from any representatives of companies who have had experience with this product over a period of three or four years. Has there been any unhappiness at termination of employment because of the difference between the cash value in the early years and what the employee has contributed?

MR. GORDON C. STREETER: I think that we at Aetna Life & Casualty were pioneers in starting the idea of employee contributions purchasing paid-up insurance. It makes an extremely simple arrangement because you can guarantee that an employee gets all his money back.

We have been offering this permanent type of program for some years. I think our salesmen have confused the issue by offering almost anything, offering to match almost any other program that any other company is willing to write. However, we do find that we make very few sales in the group permanent area when we are also offering group paid-up.

In many cases the cash-value return is not an employee problem because the bulk of the refund goes back to the policyholder. I think it is those cases that we are now having some trouble with from an IRS point of view.

MR. W. GILBERT COOK: The comment about the use of term to 65 reminds me that we have an unsettled question on this point in the interpretation of Section 79. I am not at all certain that this would be accepted by the IRS.

MR. K. T. CLARK: I am not certain either that it would be accepted by the IRS. The IRS has not spoken.

MR. ALBERT PIKE, JR.: As one possibility for getting an answer, I can say we can only ask them.

MR. ANDREW C. WEBSTER: This is an innovation in mass marketing which deserves to be encouraged, but I wonder if it would not be simpler to issue individual policies at the beginning rather than to issue group term and then convert. I am told, not on any authority, that individual policies will probably receive the same treatment as group term and group ordinary by the IRS.

The second question concerns what to do about the extra mortality which you are undoubtedly going to get on the ordinary business. There is not the control of rerating which you have in group term.

MR. K. T. CLARK: I think it would be quite feasible to work out an arrangement which did involve the use of individual policies. I suspect that not much time will go by before we see an announcement of that nature.

In regard to the mortality, the type of mortality to be expected in this arrangement is, of course, something like group mortality. Regular ordinary premiums are designed for use with individual mortality involving a strong element of selection. If normal premiums taken out of the ratebook are to be used, something has to give. Profits will be reduced, or agents' compensation will be reduced. There are perhaps some small expense economies in group ordinary. There is, for example, no underwriting expense.

There has been a trend recently for companies, which started by using premiums taken out of their regular ordinary ratebook, to adopt a different scale, a steeper scale, one which involves lower premiums at the lower ages at issue and higher premiums at the higher ages at issue. There has also been a tendency to cut commissions, especially at the higher ages at issue. And, finally, I think there has been some underwriting of older applicants which goes beyond group underwriting.

MR. STANLEY L. OLDS: It is my understanding that this arrangement is on an optional basis, optional where employees are concerned. If an employee does not take the option of the permanent coverage, his cost, as far as the employer is concerned, is the rate basis of the term policy. Why should the employee who does take permanent insurance have a different cost to the employer? Would it stand the test of discrimination?

MR. K. T. CLARK: There is that danger. I suppose you can say, though, that there is a precedent for it. An employee does not have to go into any contributory group plan. If he stays out, the employer's contribution for him is zero. If he joins, the employer's contribution for him is whatever the employer decides to contribute. Is that discriminatory?

MR. GEORGE V. STENNES: I cannot share the optimism that Internal Revenue Service will look favorably upon the tax status of such plans. In this program there is a question about the taxability of employer contributions to the employee. There should be no problem for the employer as far as his contributions are concerned.

Many problems exist. I have seen at least one instance in which employees assumed that the optional permanent insurance was in addition to the group term. There is the danger that, upon the death of an employee, his beneficiary may have the impression that there was to have been more coverage. When she gets no more than the stated amount of insurance by schedule, she may wonder what happened to the employee's contributions.

If the employee quits after one year and decides not to carry the insurance, there will usually be little, if any, cash value. This can lead to misunderstandings which could boomerang on both the insurance company and the employer.

If the terminating employee wants to convert to full permanent insurance, he is faced not only with continuing his present payroll deduction—which, let us say, is two-thirds of the total—but also with paying the employer's portion. This could lead to antiselection, which I believe could be severe. There is also the problem of whether he can afford the higher premium.

As sellers of group insurance the companies may be digging a grave for themselves. Usually permanent insurance is nonparticipating in these arrangements, but, whether it is or not, the employer's incidence of cost changes and starts out at a higher level. If half of the term insurance is changed to optional permanent, half the effect of experience rating is destroyed. I doubt if this is clearly understood by employers.

In addition, it appears that this mass-marketing proposition may be destroying an ordinary market for the benefit of agents and brokers on a basis that will not serve the best interest of the company as against good agency development.

MR. HAROLD GILBERT: There is an implicit conflict in this discussion. Mr. Clark has highlighted the role of the ordinary agent as one of the advantages of the plan. Mr. Webster has encouraged expanding the concept to include direct application for permanent insurance and simplified underwriting with mass marketing. The conflict focuses on the premium load. I suggest that development along the lines suggested by Mr. Webster will require that the role of the agent be closer to traditional group concepts with lower and often level commissions. This development could clear the way to more competitive premiums and mass merchandising.

MR. GEORGE J. VARGA: What is the average size of the policy being offered, and what is the expense?

MR. K. T. CLARK: I have only one statistic, which is gleaned from conversations with agency people and which may have some lack of mathematical foundation. I have heard it said that the average size is in excess of $5,000, and I have heard reports that the average size is in excess of $6,000. If those reports are true, your fears would vanish, I think.

Los Angeles Regional Meeting

MISS JOSEPHINE W. BEERS: The chief difference between group ordinary plans and the group permanent plans, which were common twenty or twenty-five years ago, is found in the premium provision. Instead of specifying the whole life premium for each age at issue, the contract shows separately the premium payable for term insurance and the amount of employee contribution required for the cash-value part of the coverage. Both the term portion of the premium and the employee's contribution vary by age at issue but remain level throughout the duration of the coverage. When the employee converts to an individual policy, the only adjustment in the total premium will be that required to change to the mode of premium payment that he elects.

The level premium for the term insurance is the level charge for the reducing amount at risk, assuming group mortality. The employee's contribution is the amount which, when combined with the term premium, equals the premium rate of the corresponding ordinary policy. The ordinary rate at the higher ages is not sufficient to provide for group mortality and expenses, which are initially substantially higher than the usual group expenses. Thus our guaranteed issue is restricted to ages under 65, and reduced commissions are paid on issues above age 50.

There are at least two other methods for separating the premium into the term and permanent portions. Under one method, the employer pays the cost, which increases with age attained, for the face amount of insurance, and the employee's contribution decreases accordingly. When the employer's cost amounts to the total premium of the plan, the employee ceases to contribute. The other method is similar, but the increasing payment for the term insurance is the increasing rate for the reducing amount at risk. Under both these methods, the term rate appears to be taken from the company's regular group term schedule.

There seems to be some reason for concern with regard to the employee's tax status. It has not, to my knowledge, been decided that the employer's payment of the term portion specified in these policies will qualify for the exemption under Section 79 of the Internal Revenue Code. It does seem that our policy fulfills the requirement in the income tax

regulations that the policy must specify "the portion of the premium which is properly allocable to the group term life insurance and no part of the premium which is not so allocable is paid by the employer." None of our policyholders have yet obtained a ruling from the Commissioner of Internal Revenue in Washington, but one of our policyholders has received a written opinion from one of the district director's offices that, since "the Plan sets out the term and the Ordinary premiums and further that at present only the term portion of the premiums are paid by the [policyholder]," the term portion of the premiums presently paid by the policyholder is not taxable to the employee.

There seems to be no reason for concern regarding the employer's tax status. Regardless of whether his payment is or is not taxable income to the employee, the employer's contribution would presumably be considered a necessary business expense and as such deductible from his taxable income.

This form was designed with a dual purpose in mind. The permanent insurance carried by highly paid hourly workers was usually far from adequate. By offering cash-value options under a group term contract, agents would be able to contact large numbers of such employees and to solicit many more people in a day. The employees were expected to be more receptive during the daytime and with the blessings of their employer. The fact that the employer would pay a substantial part of the premium was obviously an added inducement.

The employees who will appreciate the advantages of permanent insurance will tend to be the most steadily employed. Nevertheless, some of them will be leaving the group for better jobs. For these employees the automatic conversion to an individual policy at the original premium rate will be more favorable than the conventional conversion rights applicable to group term insurance. We reserve the right to require evidence from any employees who have been covered less than three years if the group ordinary coverage is terminated. I believe that this provision sounds much more restrictive than it will prove to be in actual practice. We do not anticipate that an employer will be changing carriers for group ordinary insurance under normal circumstances. Moreover, we do not expect to exercise our right to require evidence except in cases where we suspect gross adverse selection by the policyholder. In most instances the coverage will be converted automatically, regardless of the cause of termination of the group ordinary coverage.

One important advantage to many employers will be their right to take out permanent insurance for themselves without evidence of insur-

ability and with a substantial part of the premium being deductible as a business expense on their companies' income tax return. In addition, they should derive substantial benefits through attracting more stable employees with the help of this unique fringe benefit.

As we were working to design this plan for selling higher-cost insurance to groups who had displayed very little interest in anything but term protection, we sometimes wondered if any of the young healthy lives would elect the option. Somewhat to our surprise, we have found that one of the three permanent forms has been elected by almost a third of the individuals insured—our sales people estimate that this means two out of three individuals approached. The age distribution has, so far, been favorable enough that I, who was admittedly skeptical about offering ordinary rates without ordinary underwriting, am optimistic about this plan of group insurance.

Occidental first started to offer these options in mid-1966. The volume at the end of that year was a little over $5 million. At the end of 1967, it was just under $55 million and at the end of March, 1968, about $72 million.

MR. RONALD E. GALLOWAY: The differences between the United States and Canadian practices are in fact very minor. The primary difference is that under the tax laws in Canada it is possible for an employer to make the optional permanent insurance available to only certain classes of employees and still claim tax deductibility for the term portion of the premium. Of course, the same thing can be done in the United States, where the number of persons in the special classes is sufficient to make possible the issuance of a separate contract to them.

It is possible that the commission rates are lower in Canada on the permanent coverage than they are in the United States, although at least one Canadian company is apparently using the same scale.

With regard to the market in the two countries, the demand for optional permanent insurance seems to be concentrated in the United States. Indeed, up to now there seems to be virtually no demand in Canada. I have seen only a few sets of specifications in which the coverage is mentioned. The large brokerage houses in Canada seem to be ignoring it, and we have had no pressure from our own agents in Canada to write the coverage.

With regard to the availability of the plan in Canada, at least two Canadian companies are offering it, but I understand that most of their success has been in the United States.

One Canadian company advised us that the participation they are getting within eligible groups is of the order of 40 per cent. They feel quite satisfied if 40 per cent of the employees apply for the permanent optional insurance. They are selling a great deal of the coverage in the United States, having something over $50 million of coverage in force coming from about 150 cases, so that they are enrolling about $300,000 per case.

MR. HOWARD BOLNICK: On the split under Section 79, a great deal of the cost of insurance is involved in expenses. How are Occidental's expenses allocated between the employer and employee?

MISS BEERS: Pro rata.

MR. CHARLES MEHLMAN: My understanding is that several of the states do not have any nonforfeiture requirement applicable to group permanent. That being the case, what is the actual level of the nonforfeiture values? Are companies writing this type of business granting nonforfeiture values equivalent to what would be required under the standard nonforfeiture laws?

MISS BEERS: We grant the regular ordinary cash values, and for the reserves we put up cash values. We do not allow loan values. We did not want to change the benefits when the policies are converted.

MR. MEHLMAN: Do most companies follow that general rule? I suppose nonforfeiture values are a matter of competition, so that the values being granted correspond to the values for ordinary insurance.

MR. BOLNICK: The reason was partly competitive and partly that no one really knows what applies. We were not certain in which jurisdictions we were going to be tested for a minimum nonforfeiture benefit. This kept the nonforfeiture values relatively high.

MR. MYLES L. GROVER: Do you anticipate adverse mortality experience due to conversions, and, if so, would that be charged against the group experience or would it be paid for by the ordinary department?

MISS BEERS: We do not yet know. We are hoping that it is going to be better than the usual conversion experience. I do not believe that it would be charged against the ordinary experience.

MR. RICHARD S. MILLER: Experience in the tax-shielded annuity area should be applicable here, since the identical situation obtains, that

is, an agent being presented on a semi-endorsed basis and a payroll deduction for another product. Our experience on the tax-sheltered annuity is that the men who have been assigned to good areas have produced more ordinary life insurance in less time than usual.

Acting as a devil's advocate here, I wish to say that I believe the group ordinary product as it is being sold is a fraud. In the ratebooks of the companies that are selling it there is another product that, for the same premium dollar, will put the employee in a better situation. That product is an annual premium retirement annuity. In the first year there is at least a 50 per cent cash value. In all succeeding years that same dollar of premium applied produces more cash value than the group ordinary. If the employee is allowed an initial-age conversion right, he has the same or better benefit, because he has more cash-value conversion right. While he is in the group, the employee has a return of premium as an additional death benefit, in contrast to group ordinary. The only one that is worse off, presumably, if the pricing is appropriate, is the agent.

MISS BEERS: Are you talking about retirement income rather than full face amount?

MR. MILLER: Not a retirement income life insurance policy. Continue the group term as it is.

MISS BEERS: If all the employees proceeded to convert, I think you would be 100 per cent wrong. In theory I think you are 100 per cent right. In actual practice it is the same old question of whether one should take out an ordinary life policy or take out a term policy and invest the difference. If you invested the same amount every year and did it wisely, not cashing it in under any circumstances, you would probably do better to do your own investing.

MR. RONALD JOSEPH MARTIN: Theoretically it is true that one would probably be better off under the retirement annuity plan, but I think you would have a very difficult time selling it to the average employee. People, especially the higher-paid hourly workers, just do not buy retirement annuities; they involve too much money. You must have a package that the man can or will pay for; this, I think, is the real key to why the group permanent is easier to sell and should be more persistent.

QUESTION: What minimum employer contribution, if any, do you require before you install it?

MR. CHARLES A. LEVITSKY: We require what we would require for our group contracts. In other words, whatever is required for a group contract is extended to the group ordinary contract. We will write a group term contract provided the employer's contribution complies with the California code. Actually, we would prefer that the employer pay about 50 per cent of the term.

MR. ROBERT C. TOOKEY: How do you handle experience refunds on group ordinary plans?

MISS BEERS: In theory it would be desirable to include the experience on group ordinary in the experience rating of each case. In not experience rating group ordinary, we are open to the possibility of a policyholder's switching his unhealthy lives over to group ordinary in order to remove them from the experience rating of the term. We were also aware that a policyholder who had been receiving substantial refunds on his term experience would not be too happy if he changed to group ordinary and no longer received a refund. We tried everything conceivable to find a method of experience rating that we could live with, but we were not able to contrive an approach that would be satisfactory both to us and to the policyholders. It did not seem equitable to charge the initial surplus strain to the policyholder, but it did not seem desirable to attempt to amortize this strain and pay out refunds in the early years with no assurance that future margins would be adequate to recover the cost. We have decided to treat group ordinary as a separate nonexperience-rated class of business, and, if a policyholder cannot accept this approach, he had better not buy group ordinary.

MR. BOLNICK: We are writing a new nonparticipating policy which will include a type of experience-rating provision that we feel will lower the employer's cost to a competitive standpoint vis-à-vis experience-rated cases. We will be able to replace an experience-rated case with nonpar TOP and have the cost to the employer be as little as before. It is our answer to the necessity of a low employer cost to attract large cases.

We have been talking quite extensively of the advantages and the disadvantages to the employee of group ordinary insurance. We have brought out the fact that there are few advantages and many disadvantages to the employee. For example, the conversion privilege could be more advantageous to the employee. Companies now use an original-age

conversion, but there can be a cheaper conversion privilege if the face amount minus the paid-up value is converted at the attained ages. This, however, would be a disadvantage to the insurance company, in that another premium-paying policy would have to be issued to the convertee.

One of the ways in which this plan is sold is by the fieldmen's presenting cumulative cost to age 65 to the employer under the permanent plan and under the term plan. They say, "Gosh, you have saved a couple of hundred dollars by having employees buy permanent insurance, so every time I get an employee to enter the permanent plan you are saving money." This is a gross misrepresentation because the employee is, in general, not going to remain with the employer to age 65 and in the end the permanent portion will cost a great deal more than term insurance. As a result of this difficulty, we have devised a new plan with a change in the premium structure so that at no time do we charge more to the employer than he would be paying under the C.S.G. rate structure. We feel that this is a start toward getting into the large cases. This area is a market that has been overlooked, but it has tremendous potential. Despite the fact that I believe Continental Assurance Company has the soundest, most advantageous approach to group ordinary insurance on the market, I still have serious reservations about the usefulness of this type of product.

MR. EDWARD J. PORTO: In connection with experience rating, if lives representing 20 per cent of the volume convert to group ordinary, do the refunds stop on the other 80 per cent?

MISS BEERS: No. We rate them as if they were by themselves.

MR. PORTO: If the 20 per cent converting were the youngest employees, the average term rate would increase. Do you go back and adjust the average term rate on the 80 per cent not converting?

MISS BEERS: Not immediately, but we would.

MR. LEVITSKY: Actually, in quite a few of our cases the rate per thousand has gone down. The change is reflected in the second year.

2. *Long-Term Disability*
   a) What has been the experience under this benefit? What differences in claim levels, if any, may be expected among various types of groups, that is, small employer, large employer, professional associations, employee-pay-all?
   b) Have problems developed with claim payments or employee acceptance when integrated with social security, workmen's compensation, loss-of-time benefits, or when plan benefits are so limited that, together with other types of income, they may not exceed a specified percentage of salary? What problems are anticipated in this area?
   c) What changes in underwriting rules are emerging?

Philadelphia Regional Meeting

MR. ROBERT A. HALL: A review of LTD claim experience will include an analysis of both the rate of incidence and the termination rate. The product of these two rates, or, more precisely, the incidence rate and disabled life annuity claim value, essentially determine the level of claim experience.

The Aetna has carried out an analysis of 175,000 life years of exposure terminating July 1, 1965 (see accompanying tabulation). This exposure includes both male and female lives and an aggregate of first and renewal policy years. Plans with waiting periods of six months or less were included but only claims extending six months were counted. An average incidence rate of 2.7 claims per year per 1,000 life years exposed was obtained. This rate will vary by age.

Age Group	Experience Incidence Rate
Under 40	1.0
40–44	2.2
45–49	2.3
50–54	5.2
55–59	7.2
60–64	13.1
Average	2.7

In addition, the same claims used in the incidence-rate study were analyzed to obtain some idea of the level of our actual termination experience. The bulk of the exposure, about 85 per cent, had a maximum duration of one benefit year. The balance, about 15 per cent, extended through two benefit years. The volume of exposure extending beyond this period was so small that nothing conclusive could be drawn off.

The ratio of actual to expected reserves released by termination was 135 per cent. Expected reserves released by termination were calculated

on the basis of termination rates for Benefit 2 developed from the 1952 Disability Study with interest at 3½ per cent. Although this will vary by age, we could not conclude that we had any meaningful variation.

There are other areas of claim experience to consider which, as it turns out, have a more marked effect on LTD experience. Most important among these is the actual-to-expected experience underlying the assumptions in the scale of social security offset credits used for estimating the net insured benefit. The underlying assumptions take into account the social security benefit formula, an assumed family-composition mix, and an assumed rate of social security claim approval among known LTD claims.

The first element among these, the social security benefit formula, can be obtained directly from the law. Some variation in scheduled benefit levels in relation to earnings might be established. However, we felt that the range of taxable wage bases that we would be insuring would be so narrow that the salary-level variation would not have to be considered. To date, this assumption seems to have been sound, since our estimates of benefit levels have been reasonably close to actual experience. As the taxable wage base is increased, this assumption should be re-evaluated.

The second element, the assumption as to family composition, affects the average size of the social security benefit since the amount is based on the number of dependent children in the family unit. We have assumed that an average of 87 per cent of claimants under 40 would have family units with eligible dependents. Experience has indicated that this percentage is closer to 60 per cent. At ages 40–50 this dependency percentage ranges about 70–75 per cent, dropping to about 45 per cent at age 50. Above age 55 it is 0 per cent for all practical purposes (see accompanying tabulation).

Age Group	Dependency Percentage	
	Assumed	Experience
Under 40	87%	60%
40–44	80	78
45–49	57	70
50–54	36	45
55–59	14	5
60–64	3	.....

The third element, the relative number of social security claim approvals in relation to group LTD claims, is most difficult to estimate accurately. We studied 317 LTD claims where disability had lasted at least one year (see tabulation on page D82). These claims were all in-

curred after October 1, 1966, and were subject to the same social security test of disability. Of these claims 213, or approximately 67 per cent, were approved for social security disability benefits. The approval rate ranged from 36 per cent for claimants under age 40 to a high of 81 per cent for claimants who were over age 60. On the other hand, on the basis of our original assumptions the total number of expected social security approvals should have been 271, or approximately 86 per cent. On balance, our scale of expected social security claim approval rates anticipated 27 per cent more social security claim approvals than were actually realized.

Age Group	Social Security Benefit Approval Percentage	
	Assumed	Experience
Under 40.....	63%	36%
40–44.....	72	74
45–49.....	80	65
50–54.....	87	78
55–59.....	93	63
60–64.....	98	81
Average...	86%	67%

Part of the explanation here seems to be that the bulk of the claim experience through the middle of 1965 consists of exposure on white-collar, salaried, or executive personnel. In a large number of these cases where the individual claimant met our test of disability (basically, inability to perform his own occupation), the Social Security Administration had at the same time concluded that the individual was still capable of performing some gainful employment and, therefore, he was not approved for social security benefits. In a number of these cases we have been left with the impression that the same disabling injury or illness would have qualified for social security approval if the individual had had more limited education, training, or experience, or if his employment were basically some form of manual labor.

On balance, our most important lesson to date is in this area. Specifically, we have concluded that over-all social security offset credits should reflect a somewhat lower average benefit, taking into account relatively fewer family units and a much lower social security claim approval rate, especially at the older ages. The effect could produce an average reduction in offset credit of about 35–40 per cent. This in turn might increase insured net benefit amount estimates from 20 to 50 per cent.

Another area of interest concerns claims in which the disability is the result of a condition pre-existing the effective date of the employee's insurance. A comparison of first-year to second-year experience for our business as a whole indicates a marked decrease in actual-to-expected claim ratios. Specifically, this decrease is in the neighborhood of 8 per cent. We suspect that at least part of this differential is due to the additional claims in the first year that are not really legitimately incurred after the effective date. Probably most are long-lasting, borderline disabilities that are triggered when a disability program is adopted which is financially attractive or at least makes it palatable for these individuals to retire as disability claimants.

We attempted to see if we could analyze this in somewhat more detail; we conducted a study of 135 policies, each covering at least 200 persons. None of these policies included pre-existing condition exclusion. A review of the claims incurred indicated that between 45 and 65 per cent of the claims in the first year of exposure would have been denied or resisted if the pre-existing condition exclusion had been in the policy.

It seems reasonable to provide coverage for claims that are the result of pre-existing conditions, and, if coverage can be confined to bona fide disability pre-existing condition claims, the differential between first-year and renewal-year experience should be relatively slight. On the other hand it would seem that there are many employers who maintain on their staff a number of employees who cannot perform at the normal or average work load, but, because there is no procedure for smoothly retiring these people, they are continued on a full-time but marginal-production basis. Where the employer is both aware of and prepared to pay the potential additional cost in covering all disabilities of a pre-existing nature, it seems reasonable to provide this coverage. However, in the case of relatively small groups, where antiselection can be most effectively exercised and where actual policyholder net cost cannot follow claim-cost trends directly, it would seem inadvisable to cover all pre-existing condition claims.

Claim-settlement problems often arise simply because the claimant does not fully understand the group LTD benefit. The claimant's concept of the plan most often is formed by his reading of the announcement literature rather than either the contract or certificate. Because this literature is designed primarily as a sales tool to be used at the time of solicitation, it naturally emphasizes the attractive features of the plan, relegating to a secondary position such items as offsets and nonduplication rules. Unfortunately, many announcement booklets emphasize the level of total benefit—from all sources—that the employee will receive and do not describe

clearly enough how the operation of the nonduplication or offset provision will affect the group insurance benefit level.

Initially the claim department probably should approach each claimant assuming that he is either misinformed or uninformed. In each case the claimant should receive a detailed letter outlining the general benefit formula, including the offset provision and an explanation of the calculation of his group insurance benefit. This procedure substantially reduces the number of follow-up questions that otherwise are received.

Another area where clarity is most important is in the description of the social security disability that is included in the benefit formula offset. It is advisable to describe these social security disability benefits specifically, including both the primary insurance amount and the additional benefits payable with respect to the disabled employee's dependents if the full social security benefit is used as an offset. To do less in some cases seems to imply that only the primary insurance amount will be taken into account.

There is a practical timing problem which arises in handling claim payments involving social security benefit offsets. This problem involves the lag between the start of the series of group insurance income payments and the date of the social security award itself. In these cases there is an overpayment of benefits during this period, since group insurance benefits are unreduced with respect to the social security benefits that are payable for the same period. If the period of time between the origin of the group insurance benefits and the social security award is lengthy, the recovery of the overpayment may very well result in full offset of the scheduled benefits for what might seem to be a relatively long period of time.

This does not seem to create the employee reaction that might otherwise be anticipated. First, at the origin of the claim the employee has received a carefully written letter describing the nature of the group insurance plan and the operation of the offset, so that he is anticipating a reduction in his gross benefit. Second, it should be pointed out that he received group insurance benefits on an unreduced basis during the interim period when his social security benefit status was questionable. Finally, at the time of the reduction or suspension of benefit payments, he has on hand a large cash payment from the Social Security Administration offsetting the group insurance benefits that he might otherwise look forward to. The over-all operation works out well since, at any given time, the employee has on hand a level of income benefits in line with the scheduled benefits of the plan.

In settling claims involving workmen's compensation benefit offsets, there is the problem of allocating the award to income periods if the award

is in the nature of a lump-sum settlement. One approach is to attempt to determine the basis of the award and to use the same principles which were used to arrive at the amount of the lump-sum award in allocating it to the appropriate income benefit periods. By way of example, the award can often be broken down between compensation for medical expenses and compensation for loss of income as a result of the disabling injury. The offset would only take into account this latter part of the award. The amount of the award replacing lost income is often determined by multiplying a weekly benefit period by a scheduled weekly benefit amount. If these can be determined, the scheduled benefit amount can be used as an offset, and this offset can be applied for the period of weeks used in the lump-sum-award determination.

One of the less obvious but more significant changes in underwriting that has taken place in the last few years is a gradual drift toward the use of relatively complex benefit formulas. This may be in part the result of the policyholder's desire for a special or unique plan but, more generally, it is probably the result of an attempt to design a more equitable basis for LTD income payments. The problem seems to center on the desire to have the group insurance benefit level follow the social security benefit formula, that is, in some way reflect dependency status in the amount determination. For example, LTD plan specifications now often include provision for offsetting only the primary social security benefit at the basic benefit formula level—usually 50 or 60 per cent of earnings— then offsetting all forms of disability income, including the full social security benefit, at a higher nonduplication level—70, 75, or 80 per cent of earnings. This allows the employee with dependents to receive the additional social security benefits—not using them as a reduction in the basic scheduled benefit—and at the same time controls the over-all level of income with a nonduplication provision.

There are a number of variations on this general approach. They all produce benefit formulas that are substantially more complicated than a simple percentage of earnings. The method used to determine net insured benefits for a plan with this type of complex benefit formula must be more refined, and its application, therefore, is more time-consuming than the methods applied to relatively simple formulas. In addition, unless very deliberate pains are taken to develop explicit descriptive language, it is often not clear to the employer or employee exactly how the benefit formula will work.

Another change in underwriting which appears to be gaining momentum is the extension of LTD to hourly employees or groups not consisting primarily of white-collar employees. Pressure to continue this trend can

be expected now that the United Auto Workers have negotiated new bargaining agreements with many of the larger automobile and farm-implement manufacturers, including what are described as "extended disability benefits." The general pattern of these benefits is a long-term disability plan set at 50 per cent of earnings with offsets for primary social security benefits and the accrued disability pension. These income benefits would begin after the expiration of a fifty-two-week temporary disability, accident and sickness plan and would generally extend for the employee's length of service less fifty-two weeks but not beyond age 65. This plan clearly provides true LTD benefits extending well beyond the fifty-two-week sickness and accident period, the previous maximum benefit period.

In underwriting and rating individual plans of LTD Insurance, we are making more use of actual temporary disability experience under existing group accident and sickness plans. In addition, permanent and total disability experience under group life insurance plans can be indicative, where this experience is generated from the same group being considered for LTD benefits. Essentially, we have concluded that, although there may not be an exact relationship between past disability experience and future LTD experience, there should be a relatively strong tie.

An analysis of the past permanent and total disability experience is pretty much confined to the development of an incidence rate based on the experience itself. Since claims are not normally incurred under permanent and total disability provisions until disability has lasted nine months or longer, this should give a good indication of the relative number of long-term claims expected.

In connection with temporary disability plan experience, the relative number of maximum duration claims can be estimated from the known level of claim frequency and average duration of the weekly benefit period. It would seem that, if both the frequency and average duration for the temporary disability plan exceed expected levels, it is reasonable to conclude that the relative number of maximum duration claims will also be high. It seems reasonable to assume that there should be a fairly close agreement between maximum duration temporary disability income claims and the number of expected LTD claims in a group where the maximum benefit period under the temporary disability income plan is equal to the waiting period under the LTD plan.

These changes in underwriting require a more refined approach involving more time and effort in their application than procedures used in the past. On the other hand, we expect that these changes should produce improved plans, better underwriting results, and more extensive coverage for the over-all body of group insureds.

MR. NEIL A. PARMENTER: If I understood you correctly, your results reflect 1965 experience. Since the social security definition of disability was liberalized in 1965 and again in 1967, social security approval rates experienced in the future may well be higher than those experienced in the past. Perhaps these rates will eventually be as high as you originally assumed.

MR. HALL: The experience that we used in determining the incidence rate and the annuity claim value was based on a claim study that had its cutoff date on July 1, 1965. In determining the social security approval rate, we analyzed another block of claims, all of which were incurred after October 1, 1966. I believe that that is about the time when the test of disability was changed, not to the current one but to the one which just preceded the current one; so we have a common group of claims, and they all are on the most recent test that we can analyze.

MR. ROBERT J. MYERS: I think the change in the definition of disability that was made in the 1965 amendments was not a very large one. It has been our experience that we have not approved many more claims, so I believe this change has not made any difference.

There are different views regarding the change in the definition of disability that was made in 1967. The Social Security Administration has taken the official view that the changes have not been much of a tightening-up but have merely put into law what was previously done in practice, except for a few courts which read the law differently. On the other hand, the congressional committee that made the changes said that this was a considerable tightening. What will happen we can only know when the experience arises.

MR. HALL: I am glad to hear a rather official comment on this. I had wondered whether this was a substantial tightening or not. It looked as if it would be substantially tighter and that we could expect a good deal fewer claims than we have had. I gather, however, that you do not think that that is necessarily what you are trying to do. You are trying to get around the adverse court rulings in those few cases?

MR. MYERS: Well, they said that that was what the official view of the Social Security Administration was. Some of us and some members of Congress had a minority view on that.

MR. CHARLES E. RICKARDS: Have you any experience by size of group and so forth? Can you tell what proportions are from the various groups?

MR. HALL: I am guessing, but I would say at least three-quarters of it was from large groups; it was not broken down, however. We felt that, if we broke it down into any meaningful categories, the only thing that would be left would be large groups.

MR. WILLIAM M. ROTH: In looking over the social security figures, we found that 20 per cent of the people in the lowest income brackets accounted for roughly half of the claims. Mr. Myers, will there be a more detailed publication of the breakdown of the exposure and of the disability incidence rate?

MR. MYERS: That is a very interesting question that you have raised. We have never done anything along those lines. Our difficulty would be in getting the exposure to risk by income level. I am very much surprised by what you have asked, and I would certainly like to look into the matter.

Los Angeles Regional Meeting

MR. EUGENE H. NEUSCHWANDER: This section of the program is confined to group long-term disability. My remarks are all made toward the objective of producing a profitable end result.

The answer to item *a* is going to depend upon whom you are talking to and whom you are asking. I have found that the experience on this business varies greatly, and it depends on many factors. These factors, when they are once recognized, can become powerful underwriting tools for future operations. I will touch on some of these factors but not in the order of importance. No rigid order of importance can be made. Any one of these underwriting factors can be very unimportant or of minimal importance in one case because of the different characteristics of the groups.

Age and sex distribution.—This has importance. Watch out for age falsification, especially at the higher ages.

Economic strata of the persons being covered.—The best way to evaluate this factor is to go into the plant where the people are working and take a look at them. Walk around the plant, see what goes on and what kind of people are working there; in this way you can get an idea of the economic strata of the people.

Level of benefits.—See how this is related to the take-home pay of the lower-paid employees and to the net after-tax income of the higher-paid employees.

Type of industry and its cyclical nature.—Industries that have cyclical ups and downs produce problems.

Duration of benefits.—I strongly urge you to cut off all benefits at age 65. Do not give lifetime benefits in event of accident.

Scope of coverage.—Are you providing nonoccupational or full twenty-four-hour accident coverage? If you are providing full twenty-four-hour accident coverage, be sure to examine the workman's compensation record of the employer.

Turnover rate.—Consider the turnover rate of the persons to be covered. Does the employer set his own hiring standards, or are the hiring standards dictated by a union? Does the employer have to hire whomever the union sends him?

Current economic conditions.—Long-term disability is most sensitive to economic fluctuations. When times are good and wages are high, people stay on the job. When times become bad and unemployment develops, a different picture emerges.

Pre-employment physical examinations.—Does the employer have pre-employment examinations for his employees? Do not obtain a simple "yes" or "no" answer on that. Investigate to see who makes the decision, who it is that reviews pre-employment physicals and decides whether the man is fit to be employed or not. The pre-employment examination is no good at all if nobody acts intelligently on it. And remember—the employer or whoever is making the decision on those examinations is not a disability underwriter. He is looking at the examination from an entirely different standpoint.

Enrollment percentage.—Are you getting a heavy percentage of enrollment or a light percentage? This is especially important for association business.

Record with the previous carrier.—If there has not been a previous carrier, watch out for claims that are lying in the bushes. Almost every employer that is going in for a long-term disability plan for the first time has claims all ready for airing as soon as the coverage is written, involving people that he has had problems with for months and years past. He did not want to fire them; he wanted to be good and take care of them, he kept them on the payroll and gave them a little light work. As soon as he gets a long-term disability plan, he drags them out and says, "Here, they're yours now." One way of coping with this problem is to put into your contract a thirty-day return-to-work provision.

Individual underwriting procedure.—I highly recommend that you consider individual underwriting if you are doing association business, be-

cause you can lay down some individual underwriting requirements and, if you are getting a high percentage of enrollment, you can temper the requirements and relax them.

Source of business.—Where is your business coming from—from your own known producers or from some producers who have shoved the case around from one company to another? I have been caught in the latter situation two or three times, and there is a phrase that I learned long ago that seems to apply: "Sleep with a dog and you get fleas."

Co-ordination of benefits.—Consider the other possible coverages: (1) social security—be sure that you have it co-ordinated on a family basis. (2) workmen's compensation—this must be co-ordinated if you are writing twenty-four-hour coverage. (3) Group life installment payments—a sizable number of outstanding group life contracts have such benefits. (4) Retirement plans—the disability benefits of these plans must be considered. (5) There is also statutory disability in four states.

We placed a long-term disability plan in our own company in 1964. When we investigated the benefits that our people then had, we found that they had disability benefits coming from seven separate and distinct sources and some of these overlapped. It was like dropping seven pieces of paper on the floor. There were overlaps, but there were holes, so we instituted a whole new program.

Contract terminology.—Have your contract just as clean and definite as you can make it, and put in that thirty-day active-work clause that I mentioned.

Claim settlement and rehabilitation procedures.—Remember that you are dealing with claims, many of which will be measured in hundreds of thousands of dollars. Have a claim-settlement procedure that tries to get the people back to work—a rehabilitation arrangement.

Association business.—Try to determine whether the association is planning to use long-term disability as bait to catch new members. If so, you will be the one who gets caught. The only practical way to write association business is on an individual underwriting basis and with rates by age.

Item *b* has to do with claim problems, where other benefits reduce the amount payable under your own claim. This has been a problem, but with our company it is a minor one. We find that many employees who have this coverage are quite unaware of what their benefits amount to in dollars, so employee acceptance is not adversely affected. When they become claimants, there is a problem. One way we have found to cope with the situation of the other benefits eating up the long-term

disability benefits is to grade the employee contributions so that those employees who will be receiving very small long-term disability benefits will be paying little or no employee contributions. One factor not to be overlooked in the integration of social security benefits is that, every time social security benefits are increased, the insurance company gets a windfall. The money going out in claim payments is reduced, and, what is more important, the reserves for all outstanding claims are reduced.

Item *c* mentions underwriting changes. Long-term disability underwriting rules are highly dynamic. Each underwriter must continually review his technique to continue in this field on a profitable basis. This business is rather different from other forms, since it will generally take about three years, and sometimes longer, before the underwriter knows whether a group is operating on a sound basis. Even then his conclusions may be in error if claims are not being properly reserved. Developing an adequate and realistic claim-reserve procedure is one of the biggest problems in the business today.

The following statements summarize concisely the substance of what I have been saying:

1. It is extremely important to have this line of business handled by competent, experienced, imaginative personnel. One quality stands out above all others —the vision to see where you are going. Avoid putting this business in the hands of amateurs.
2. Have clean, understandable contracts with a minimum of ambiguity, and do not provide coverage beyond age 65. You cannot provide retirement income coverage at disability rates.
3. Develop a reliable source of business.
4. Have a benefit structure that provides adequate but not excessive amounts of coverage with the proper co-ordination of benefits on a payable–not paid basis. In other words, arrange it so that you cut down your payments when social security or other benefits become payable. As mentioned before, have a thirty-day return-to-work requirement as of the effective date of coverage for each person.
5. Have good, clean claims-settlement procedures with some rehabilitation procedure worked in.
6. Have adequate reserve procedures for your claims.
7. Have a rating procedure sufficiently flexible to cope with all the major items which affect claim levels.
8. Have an underwriting procedure sufficiently sophisticated to recognize and evaluate all these items.

If you follow these suggestions, you should be in business profitably, but you won't set the world on fire with volume. There always seem to

be new companies entering the field who have yet to learn two basic lessons in this business: (1) If it can happen, it will. (2) Hope makes a fine breakfast but a damned poor dinner, and a lot of companies who get into this business have not recognized when dinner arrives.

MR. RONALD E. GALLOWAY: In Canada the current personal income tax law excludes from income any amounts received by the taxpayer as proceeds under income-replacement insurance. For this reason it is necessary to limit the amount of benefits payable under long-term disability to a lower per cent of gross salary in Canada than in the United States, and this is particularly true for amounts of benefits in excess of $100 a week, which come from employer sources.

This does not mean that the pressure for a high level of benefit is any less in Canada than it is in the United States, and on this I might relate the situation presented to us by one of our very large Canadian policyholders. The benefit being proposed was 65 per cent of salary at the lower levels; the union insisted on a higher benefit because in the city of Toronto some of their members would, in the event they became disabled, do better to go on welfare. So we wound up with a benefit of 75 per cent of gross income during the first year of disability.

Apart from the differences in underwriting rules due to the differences in the tax laws of the two countries the markets seem to have developed with other slight differences. We note, for example, that there is less of what I call gimcrackery in the benefits being sold in Canada, such as minimum payment period or lifetime benefit, or cash indemnity for certain specified injuries, and there is less demand for the lifetime accident in Canada.

There appears to be a difference also between the approaches taken by Canadian companies and United States companies operating in the Canadian market. For example, most Canadian life companies are using a par approach to the long-term disabilities, at least for their Canadian business, whereas the United States companies appear to favor the nonpar approach. This no doubt explains why we see more cases in Canada in which there are questions on the details of the insurer's par approach.

Canadian companies seem to be more conservative than the United States companies in establishing the maximum amount of benefit that they will permit on any one life.

With regard to claim experience, our own experience indicates that claim rates are somewhat higher in Canada. However, our Canadian and United States business is quite different in character, in that the bulk

of our premium income in Canada comes from very large groups, whereas much of our business in the United States is on groups of less than twenty-five lives, for which your underwriting requirements are much more stringent. Under these conditions it is difficult to determine whether the more favorable results in the United States arise from general morbidity levels or from more selective underwriting.

As to the integration of benefits with other disability income, it seems that there is less resistance to the integration in Canada than there is in the United States and we integrate not only with all the items enumerated but also with individual income-replacement policies. I am not sure that is permitted in all states of the United States, but we are doing it wherever it is permitted in both the United States and Canada.

Talking about differences in coverages in the future, I can foresee the day when it will be necessary for all companies to include a conversion privilege in their group long-term disability coverage. This is the most satisfactory answer to the reluctance of an employee to drop an individual policy when applying for group coverage, for fear that when he leaves the employer he will be left without protection. We have for some time now been including a conversion privilege in all our group long-term disability policies.

MR. ROBERT C. TOOKEY: Do you believe in winner-take-all on experience rating, or do you have experience refunds under your group long-term disability contracts?

MR. NEUSCHWANDER: I will say that at the moment we believe in winner-take-all. However, that is not true in all cases, because we have negotiated some of the larger ones on a retention basis. But operating on a retention basis produces almost the same result if you manipulate the claim reserves right. In this business it takes at least three or four years before you know where you are on any one case. We have only been in this business about that long, so there really has not been too much pressure yet for refunds or experience rating.

MR. CHANDLER L. McKELVEY: You emphasized the importance of reserves. Is it the normal practice to use the fire and casualty approach and give an evaluation of each reserve, or do you use a table?

MR. NEUSCHWANDER: We are, as a general rule, using the table laid down by the insurance commissioners a couple of years ago. We have made some modifications for the first two years.

MR. BARRY S. SUTTON: This underwriting of association cases is well brought out in Canada. I am familiar with a couple of provincial medical associations there, which should have the same character as the AMA. Because they have been individually underwritten, the incurred loss ratios have been running under 40 per cent for over ten years through numerous rate reductions.

3. *Medical Care Expense Insurance*
   a) What has been the recent claim experience under the various basic coverages? Under supplementary major medical? Under comprehensive?
   b) What are the underlying causes of recent trends in these coverages? What changes in these trends are likely in the next year or two?
   c) What effect has Medicare had on plan design for those under 65? At the time Medicare was introduced, many approaches to the plan design of insured plans for those over 65 were developed. What has been the success of these various approaches—both from a claim-administration standpoint and also from a public-acceptance standpoint?
   d) What effect does COB have on the claim experience? On the lag between paid and incurred claims?

Philadelphia Regional Meeting

MR. ROBERT D. CARPENTER: Topics *a* and *b* are very much interrelated. One of the problems, of course, is to give a meaningful evaluation of current claims experience. In these days of such rapidly rising medical costs, by the time significant studies can be made of the claims experience, the results are pretty much out of date.

It might be interesting initially to consider the over-all claims experience under the group health lines before relating to the different types of coverages. We have had an opportunity to review the 1967 annual statement of twenty large United States life companies writing group health insurance. The results are not really too encouraging, but they are nowhere near as bad as might be expected.

Schedule H results in these companies indicate losses after dividends for fifteen out of twenty companies. Five managed to show positive Schedule H results. This compares with comparable results in 1966, when seventeen of these companies had losses after dividends and only three had positive Schedule H results. Of these twenty companies, ten actually showed an improvement in the Schedule H results, that is, the black figures were more black than last year or the red figures were less red.

Another major Schedule H result can be determined from the claim ratios taken from line 15(d), which is the "ratio of incurred claims to earned premiums without deduction of dividends."

Twelve out of the twenty companies have a higher claim ratio in 1967 than they had in 1966. These claim-ratio indices range from two-tenths of 1 per cent to a high of 6.1 per cent. For those companies which are fortunate enough to have decreases, the percentage of change generally was greater than it was for those that had increases.

The group accident and health column on page 5 of the Annual State-

ment reflects the net contribution to the company's operation, expanding the figures shown in Schedule H to include net investment income, federal income tax, and transfers from other lines.

Here the group health operations show up a little better, as only nine companies showed red ink, compared with ten in 1966, and ten showed better results than in 1966.

All in all, in the face of skyrocketing medical expenses, the fact that over-all results in the group health line show up as well as they do in this rather limited survey is quite encouraging. That is not to say that there is not a rough road ahead or that the problem is whipped, because increasing medical costs keep hanging over our heads.

At this point I would like to set forth a few of the factors that I think have contributed toward the reasonably satisfactory results outlined above, although I am not sure what the relative contribution of each one was.

The first factor was the removal from insured programs of the great majority of the exposures of persons over age 65 when Medicare became effective.

The second one, and closely allied with the first, is a decrease in admittances to hospitals, along with a reduction in the length of confinement, for those persons under age 65 because of the great demand for hospital beds by those persons eligible for Medicare. I am not aware of any studies that have been made that actually demonstrate this, but it is one thing that you know must be right from your general observation.

The third factor is a rapid recognition, through tougher renewal underwriting, of the need to reflect quickly in rate adjustments the deterioration of the experience under a policy or class of policies. I think that there has been a much slower recognition of the higher premium requirements for new cases, but this situation is currently being remedied.

The fourth element is the adoption of more group programs with some type of control element—a limit on daily room-and-board benefits in a basic hospital, higher or more extensive initial deductibles, or a limit on semiprivate accommodations under major medical.

A fifth contributory factor is that during this period co-ordination of benefits provisions have become widely adopted; this has had some measure of effectiveness, although it is impossible to measure accurately.

The sixth element—and I think this one has played an important part—is an upgrading of the benefits provided under group policies to reflect the higher expenses and to bring in the increased premiums developed from the higher benefits.

To try to prepare myself a little better and to reflect other experiences as well as our own, I sent out a ridiculous questionnaire, which I asked a number of other companies to complete. While no one was in a position to give me the information requested—including my own group actuary, who said he surely wished that he could—I did get replies from almost everyone I asked, with some very helpful information.

Very interestingly, many of the companies indicated that, under basic hospital and surgery coverage, claims ratios for 1966 and 1967 were fairly steady. Of course, during this period the six factors that I discussed above played an increasing role, so that actual claim costs for these benefits probably have increased.

There appeared to be some indication that claim costs for ancillary hospital charges are increasing and that there has been increasing utilization of outpatient services, but over-all experience does not generally appear to be too bad.

It is quite a different story, though, with respect to major medical coverages. Our own experience indicates that claim ratios for supplementary major medical may be anywhere from 10–15 per cent higher for 1967 than they were for 1966, and this is borne out by the results furnished by other companies. I would predict that, when studies are subsequently made with respect to the 1966, 1967, and 1968 experience, they will show that costs under supplementary major medical benefits increased at 2 or 3 times the previous rate, more in the range of 10–15 per cent a year.

Other information that has been developed indicates that, for hospital and surgical base benefits, claim costs increased approximately 10 per cent during 1964 but have been relatively stable since that time.

It is too soon yet to tell what 1967 experience will show under this study, but I predict no greater than a 5 per cent increase.

The second topic is one that is most important to our future operations and one that is the most difficult to predict. There is no question that the same pressures that have caused the rapid increases in medical costs in the past few years still exist and that some are even more pressing currently. I would list eight of these:

1. A great demand for medical care and a shortage of supply of trained technical personnel along with the concept that high-quality medical care is a right.
2. Medicare and the great demand for hospital beds.
3. The tremendous strides made in medical technology and the high cost of new medical equipment.
4. The increase in ratio of personnel to patients in hospitals and the number of health-workers for each physician. Unlike most other personal services, hospitals operate on an around-the-clock basis and need people all of that time.

5. The dramatic increase in wage levels for nurses, technicians, and all other hospital personnel, with more to come in this area.
6. The less-than-modern administrative techniques in many medical facilities.
7. The general high cost of money.
8. All the other general inflationary pressures.

Undoubtedly, these will cause continuing increases for the next couple of years in the same general range as those of the last couple of years. There are, however, increasing signs that the public is becoming aroused by these spectacular increases; the topic has become page 1 for the newspapers and a subject for magazine articles and editorial writers, and it has achieved a high priority on the politicians' list.

Recently President Johnson, in his Health Message, called for a study of ways to control these costs. Governor Rockefeller, in introducing his bill providing for compulsory health insurance in New York, included provisions to attempt to control hospital costs, and a number of Senate committees plan to hold hearings on this subject.

The March issue of *Forbes Magazine* devotes a great deal of attention to the issue of higher hospital costs. It points out that hospitals have become such big business that big business itself has become interested in providing medical services and is attacking the problem from many directions. These would include computerization and systems design for admittance, record-keeping and testing, and so forth, developing more sophisticated medical technology systems and equipment and taking an entirely different approach to the provision of medical care through preventive medicine and the establishment of different types of medical centers.

Companies that have been working in the aerospace industry are moving into the health field—General Electric, Litton Industries, TRW, Honeywell, Lockheed, North American, and Union Carbide.

Another approach receiving great attention these days and being kept in the limelight by the federal government is prepaid group practice. Last fall the government sponsored a conference on group practice; a number of union leaders have indicated their great interest in it; the most successful of these plans has indicated its intention to go national; and a number of insurance companies, probably some of you, have been working with certain medical schools and the American Medical Association to find out what role the insurance companies can play.

It does appear that there must be some point above which increasing premium rates will not be acceptable to the public to provide protection against medical expenses. Just what that point is, is difficult to predict, but I personally would look for real buyer resistance if the rate of increase

were to continue unchecked for more than a couple of years. It will be a very interesting period.

Turning now to the questions on Medicare, I would like to express a personal opinion. I think a remarkable job has been done in recognizing Medicare as a fact of life and of adapting our operations and services to this fact for the over-all good of the American public.

Those of us who have not participated in the administration of either Part A or Part B certainly owe a real debt of gratitude to those companies that have and have done such a good job of it. I think that this has been a very important reason that such a radical change has been adjusted to so quickly and easily.

I have been somewhat surprised at the minimal effect Medicare has had on plan design for those under 65. In my own company we developed a product at the time Medicare became effective which is very similar to Medicare benefits, and, aside from whatever credit we got from our field force for keeping up to date, this did not contribute much to our sales results. Our rating structure may have had something to do with that.

The companies which I contacted indicated that to date there has been little or no effect on plan design for those under 65, except possibly with respect to the more general availability of coverage for extended-care facilities and one company indicated a current flurry of interest in home care.

With respect to plan design for those persons eligible for Medicare, a number of approaches were used initially, and most policyholders were offered a choice. These choices can probably be summarized as (1) complete termination of coverage; (2) a plan of specified benefits; (3) benefits for expenses not covered by Medicare, generally not attempting to fill in the deductibles or coinsurance; (4) integration or carve-out; and (5) co-ordination of benefits.

In some respects it is a matter of semantics as to which is which, but generally the policyholders chose that plan of benefits that the carrier was recommending. Apparently, once the decision had been made, there have been few requests to change, although one company has indicated that a number of policyholders have moved from a plan of specified benefits to a co-ordination of benefits approach.

With respect to claim problems, there would be none under the first three approaches. Under the integration or carve-out approach and co-ordination of benefits, the claim problems that develop do so because of the necessity of finding out what Medicare has paid. This has resulted in delays and questions about what benefits are provided by Medicare and what benefits are provided under the group policy. In my own company

we decided to approach this on the simplest and most practical basis that we could think of. Therefore, we developed a plan of benefits filling in the first $40 of hospital cost, not providing benefits for any other expenses provided by Medicare or used as a deductible or coinsurance but providing under major medical coverage for such items as drugs and private-duty nursing, for which Medicare provides no benefits. Under this approach we provided some benefits but did not get involved in claim problems.

We took the straightforward approach that all our policyholders wanted this type of coverage and sent out an amendment without offering any choice. It worked extremely well, and we had almost no problems in getting policyholder agreement and have had practically no claim problems.

The last topic, co-ordination of benefits, represents something that is very tough to live with but impossible to live without. The savings attributed to COB vary by company and by policy. The figures reported by Companies A–G include the following:

A. 1.8 per cent of claims paid in 1966; 2.9 per cent in 1967.
B. 3–5 per cent.
C. Over all, 3–4 per cent; some policies, 10–11 per cent.
D. 2–4 per cent, with the amount varying according to the percentage of married females and whether or not they elect dependent coverage, percentage of males with working wives, the per cent in COB and other plans and richness of plan benefits.
E. 2.3 per cent.
F. 1½–12 per cent.
G. 0–16 per cent.

Although the percentages may be small, in terms of dollars the amounts are large; and, referring to my initial figures, we see that this can well be the difference between the red and the black ink.

Problems have developed as a result of COB. It seems to be fairly well agreed that it usually takes about two weeks longer to pay a claim when COB is involved. There is almost unanimous agreement on that figure.

The problems that have developed in addition to the delay are those that would be anticipated:

1. Unhappiness of doctors and hospitals over delay in claim payments.
2. Unhappiness on the part of the employee because of misunderstanding of COB provisions.
3. Increased cost of paying claims.
4. Unhappy policyholders because of delay and employee problems.

5. Trouble in obtaining information about coverage, particularly from organizations without COB provisions.
6. Identification of claims when COB is involved.
7. Unpopularity with unions.

Even though COB does have its problems, I do not know of anyone who would want to go back to the pre-COB days. Our operating margins are too small. In general, I think it would be agreed that COB has accomplished its purpose.

MR. SAUL S. LIPKIND: On the COB savings figures, I did not quite understand whether these were claim savings or net savings less administrative expense.

MR. CARPENTER: They were purported to represent claim savings.

MR. MYERS: One thing that I would be very much interested in is the success from a financial standpoint of the various approaches of plans supplementing or complementing Medicare.

MR. CARPENTER: In our company I think the premium rates that we have established have been just about adequate.

Los Angeles Regional Meeting

MR. JOHN MAHDER: Prior to the 1960's the Society's Group Morbidity Committee published an annual report of aggregate policy-year experience of plans that provided temporary disability income and basic hospital and surgical coverages. During the early 1960's it began to collect experience under comprehensive medical plans, even though there were fewer lives insured for comprehensive medical than for supplemental major medical. I suspect that two of the reasons for this choice were (1) the high annual claim costs for comprehensive medical, which would generate meaningful volumes of experience on the lives available for study, and (2) instructions for contributing companies and a tabular could be developed more rapidly for comprehensive medical.

The Gingery-Mellman paper, based on actual comprehensive claims, could be used to obtain the claim cost variations, and there was no problem with underlying basic benefit plans. The Burton-Pettengill paper on comprehensive medical tabulars was presented to the Society in 1963 and has been used as a basis for subsequent annual reports of the Group Morbidity Committee.

After the comprehensive medical study was well along, instructions for supplementary major medical contributions were prepared, and we were asked to prepare a tabular claim basis. Briefly, a fourteen-step tabular is used to calculate "expected" claims for supplementary major medical plans. The paper contains a report of actual to tabular experience. The tabular presented in the paper was developed after trying several methods of calculating expected claims. By no means did we exhaust the possible ways of calculating these values. Of those tested, the method presented seems to do the best over-all job.

Variations in claim costs by age and area are different for comprehensive medical and basic medical. At one point we tested a tabular with comprehensive medical age and area adjustments applied to the no-base-plan values and a different scale of age and area adjustments applied to the base-plan reductions. We settled on single area and age adjustment scales, since results are reasonably good and single age scales and area scales are much easier to understand and to handle in the calculation procedure.

Factors which caused the most difficulty were the establishment of area variations in costs, the level of reduction for basic benefits, and how to vary the amount of reduction between very modest and very rich basic benefit plans.

The tabular is quite sensitive to changes in either the basic tabular costs or the level of reductions for base-plan benefits. A change in either has a substantial effect on Table 17, actual to tabular ratios, by per cent total reduction. Because of this, I believe the tabular will require periodic adjustments as base-plan benefits are increased to reflect the substantial increase in charges by hospitals and physicians. Without this change, even average hospital basic benefits will soon exceed the maximum hospital reduction established in the tabular.

I would like to make an observation concerning interpretation of the experience results shown in the paper. Supplementary medical experience fluctuates widely on given cases from year to year, and the results as shown in the paper may turn out differently when subsequent experience is available. The tabular does not, however, reflect all the factors which influence claim costs, and interpretation of results should be made with this in mind.

Finally, as was indicated in the paper, the tabular that we presented is a beginning, not the end. We believe the tabular does take into account the principal factors which influence claim costs under supplementary major medical plans. Mr. Pettengill and I are both hopeful that members

of the Society will contribute experience and/or suggestions that will lead to improvements in the development of future tabulars.

MR. EDWARD J. PORTO: Are the tabulars for the various deductibles constructed from one set of claim data?

MR. MAHDER: In the *comprehensive* tabular we did review claim experience which was primarily under $50 deductible plans. Claims between $50 and $100, between $50 and $150, and so on, were removed to obtain variations in indicated actual claim experience by deductible for these plans. The values adopted in the major medical tabular, however, do have some adjustment for the fact that the claim costs under a $100 deductible plan will probably be different from theoretical $100 deductible claim costs obtained by adjusting $50 deductible experience to remove costs between $50 and $100. I think that future major medical experience will indicate that for the $50 deductible plans, for example, there is not enough adjustment in the tabular as it now stands to reflect this characteristic.

MR. EUGENE H. NEUSCHWANDER: What is the trend? Medical science progresses with time, and there are many changes. Certain ailments that were in the past short and of a terminal nature are now, at great expense, being cured; many ailments that previously were of a long-term nature are now cured very quickly. Have you any idea of what the net effect is as medical science progresses?

MR. MAHDER: In order to answer this, I suspect that you would like the inflationary effects taken out. I cannot take out the inflationary factor. I do not know what the answer would be. I can state, though, that, in looking at our studies of comprehensive medical claim experience, we do continue to see an increasing frequency of claims per 100 persons insured. A good deal of this, of course, will be due to the fact that, whereas you used to have a $40 charge and no claim, the charge is now $60 and a claim.

MR. RONALD E. GALLOWAY: I am going to confine my remarks to a report on the status of Medicare in Canada.

Under Bill C. 227, which was passed by the House of Commons in 1966, the federal government will pay approximately one-half of the cost of any provincial surgical-medical plan which meets the standards laid down by the bill. The scheme was originally slated to begin on July 1,

1967, but for budget reasons was deferred to July 1, 1968. Each of the ten provinces is therefore in the position of having to decide whether it will come under the plan on July 1, 1968. So far, only two have decided they have the money. One of them, Saskatchewan, already has a plan, so in their case the federal government money will be found money.

The real problem is that the residents of all provinces will be taxed by the federal government to help finance the federal contribution to those provinces which do enter the plan. There is, therefore, some incentive for a province to come into the plan to get its share of the pot.

There is considerable opposition to the terms of Bill C. 227 on the part of several of the provincial premiers, but up to the present this has been countered by the argument that the bill is the "law of the land" and cannot be changed without the approval of Parliament. As you are all aware, however, we have just had a change of prime ministers, and this change in leaders does make more possible a reconsideration of the federal government's rules for Medicare. It appears unlikely, though, that any significant changes will be made. We must conclude, therefore, that we will have a form of Medicare on July 1, 1968, in two provinces—Saskatchewan and British Columbia. In the meantime other provinces will be trying to get changes in the legislation which would make participation in the scheme less costly.

MISS JOSEPHINE W. BEERS: May I ask the assembled representatives of our competitors one question? We changed hospital-surgical major medical rates on January 1, 1968. Our sales people are telling us that our competitive position is much worse today than it was in November of 1967. Has your experience been such that you are lowering rates in California, for instance?

MR. WILLIAM CUNNINGHAM: We ran computer studies for 1965, 1966, and 1967, seeking some kind of trend. We had good financial results in 1967. On a base of $50 million of annual premium, the actual-to-expected loss ratio decreased.

The decrease of loss ratio in 1967 is due to two factors. On basic medical there is an increasing coinsurance factor because of the increase in hospital costs and because of Medicare. This is not just in the medical, as our short-term disability has also improved 10 per cent in 1967 over 1966 and 1965.

We followed the hospital experience by calendar quarters for one particular case having 25,000 people insured, and we found that in 1967 there were an 8 per cent decrease in the number of hospital days per

employee and a 16 per cent decrease on the dependency side. It is good to be in this position, but I am concerned about what is going to happen this year.

MISS BEERS: How about 1968? Have you seen actual rate reductions in any of your competitors?

MR. CUNNINGHAM: Not so far as rates are concerned but on individual cases in competition, yes. I am talking about cases that are out for bids. What we are seeing is what we saw back in 1958 and 1959, and the companies are going to lose their shirts.

MR. PORTO: We also experienced a dip downward in 1967, but the early experience in 1968 is worse than it was in 1967. It appears to have been only temporary.

MR. CUNNINGHAM: I think you are right. What bothers me is that, if you have a $30 per day plan and the policyholder wants to increase the benefits to $50, he knows what your hospital experience was last year and wants you to base your rates per dollar on last year's experience. I do not think you can do it.

MISS BEERS: We had the experience mentioned too, but we had a break. We tried to adjust the reserves, but I do not really know whether we adjusted them properly for the period.