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RELATIONSHIP OF THE ACTUARY TO THE POLICYHOLDER

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1. Non-discrimination Regulations
2. Improved Service to the Policyholder
3. Dividend Philosophy
4. Cost Comparisons and Disclosures

MR. ALAN E. LAZARESCU*: I will begin my discussion regarding sex discrimination relating to insurance and pensions in an employment situation with a brief review of Title VII of the Civil Rights Act of 1964. Title VII prohibits an employer from discriminating as to compensation, terms, conditions and privileges of employment because of race, color, religion, sex or national origin. There is an absence of any meaningful legislative history pertaining to the Act's proscription of sex discrimination. The only available material indicates that the provision in question was introduced into the Act in an attempt to delay and obtain the defeat of the Act. However, the Act was passed and Title VII became effective on July 2, 1965.

The Equal Employment Opportunity Commission (EEOC) was created by the Act and it is charged with the responsibility of administering and enforcing Title VII. I believe that you are aware of the fact that the EEOC is vigorously attempting to enforce Title VII and EEOC guidelines in the area of sex discrimination in insurance and pension plans. An employer's insurance and pension plan for its employees clearly falls within the broad language of Title VII. Employers have been held to be liable for substantial damages because their insurance or pension plans unlawfully discriminated on the basis of sex.

It should be noted that the provisions of Title VII mentioned above are specifically aimed at unlawful discriminatory practices by an employer and they are not applicable to any form of discrimination outside of the employer-employee relationship. One question which arises is should an insurer be held liable for damages in a case in which it issues a group plan to an employer and the plan is determined to be unlawfully discriminatory. I have always taken the position that an insurer should not be held liable because: (i) Title VII is specifically aimed at unlawful discriminatory practices by an employer; and (ii) an insurer is marketing a product and it is generally willing to issue almost any kind of coverage an employer is willing to pay for. In a recent decision (No. 75-132-January 9, 1975) the EEOC upheld this position.

Most states have employment discrimination statutes similar to Title VII. In the situation mentioned above, insurers have been dismissed from the state proceedings in all of the cases I am aware of. In one state (New Jersey) an insurer is being charged, under a general discrimination statue, with unlawful discrimination for failure to provide maternity coverage to a single woman. The

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state agency is claiming that it has jurisdiction over the insurer under the "public accommodation" provision of the statute. To date, there has not been a hearing in this case.

A matter of considerable interest and activity during the last few years has been the pregnancy disability question. In 1965 the EEOC issued guidelines which did not cover disabilities caused by pregnancy. During the years 1966 through 1968 the General Counsel of the EEOC responded to specific inquires regarding the appropriate treatment of pregnancy under medical expense and disability plans. The General Counsel stated that the EEOC's policy does not require an employer to provide the same fringe benefits for pregnancy that it provides for sickness and accident because pregnancy is a unique disability in females which cannot be equated with a disability caused by sickness or accident. In 1969 the EEOC rendered a decision (Decision No. 70-360-December 16, 1969) reaffirming this policy. In 1971, six years after the effective date of Title VII, the EEOC changed its policy and held that an employer must provide a benefit for a disability caused by pregnancy which is equal in rate and duration to the nonoccupational sickness and accident disability benefit the employer provides for all its employees, male and female (Decision No. 71-1474-March 19, 1971). This new policy was incorporated into the March 31, 1972 comprehensive revision of the EEOC's sex discrimination guidelines.

It should be mentioned that the EEOC's position in this area was adopted by the Department of Health, Education and Welfare in its recently promulgated sex discrimination guidelines for educational institutions receiving federal financial assistance.

At this time Geduldig v. Aiello, 417 U.S.484 (1974) is the only case that has been decided by the United States Supreme Court in the area of pregnancy disability. The Court held, in a six to three decision, that exclusion of a normal pregnancy from coverage under a State's (California) disability plan for all employees within the State was not a violation of the Equal Protection Clause of the 14th Amendment. In reaching its decision, the Court relied heavily on the State's argument that providing a disability benefit for a normal pregnancy would have a severely adverse economic impact on the plan. The issue decided in this case is narrow and it does not cover such questions as: (i) whether complications of pregnancy can be excluded from coverage under a State's disability plan; and (ii) whether the EEOC's position pertaining to pregnancy disability benefits under Title VII is correct.

There are several reported cases involving the pregnancy disability question under Title VII. However, as far as I am concerned, only two of these cases are significant at the present time. The first case is Wetzel and Ross v. Liberty Mutual Insurance Company, 372 F. Supp. 1146 (W.D. Pa. 1974). In this case the United States District Court held that the EEOC's guidelines were entitled to reference in interpreting Title VII and concluded that the employer's arguments pertaining to higher costs and the voluntary nature of pregnancy were not relevant to the issue presented. It does not appear that the employer argued that pregnancy is not a sickness or an accident. The Court of Appeals, 508 F.2d 239 (3d Cir. 1975), affirmed the decision and stated that Geduldig v. Aiello is not relevant in a Title VII case. The Court stated that

> "Geduldig v. Aiello involved the question of whether there was sex discrimination in violation of the Equal Protection Clause of the Fourteenth Amendment. Here we are involved with the question of whether there was discrimination in violation of Title VII of the Civil Rights Act of 1964. In this posture our case is one of

statutory interpretation rather than one of constitutional analysis. On this distinction alone we believe appellant's reliance on Aiello is misplaced."

The United States Supreme Court has granted the employer's (appellant-defendant) petition for a Writ of Certiorari and the case is scheduled to be argued during the Court's October term. Amici briefs have been filed by a number of insurance trade associations, including the Health Insurance Association of America (HIAA) and the American Life Insurance Association (ALIA). The HIAA and ALIA are supporting the employer's position that Title VII does not require an employer to provide a disability benefit for a normal pregnancy. It should be mentioned that the HIAA and ALIA do not oppose a disability benefit for complications of pregnancy because complications of pregnancy are fortuitous and can be equated with sickness or accident.

The second significant case is Gilbert, et al. v. General Electric Company, 375 F. Supp. 367 (E.D. Va. 1974). In this case the plaintiffs alleged that the employer was violating Title VII and the EEOC's guidelines by not providing a pregnancy disability benefit. The United States District Court briefly mentioned the EEOC's position and construed Title VII as requiring that a sickness and accident disability plan cover disabilities related to pregnancy on the same basis as other disabilities. The Court of Appeals, F.2d (4th Cir. 1975), affirmed the District Court's decision. The Supreme Court has granted a petition for a Writ of Certiorari and this case will probably be argued together with the Wetzel case.

A decision by the Supreme Court in Wetzel and Gilbert in favor of the plaintiffs will basically render academic the question of whether state employment discrimination laws require an employer to provide a pregnancy disability benefit because most employees are employed by employers that are subject to Title VII. A decision in favor of the defendants in the above mentioned cases would be a substantial victory for employers. However, employers would still have to contend with the question of whether state employment discrimination laws require a pregnancy disability benefit. To the best of my knowledge, all of the state agencies that are responsible for enforcing such laws take the position that an employer is required to provide such a benefit on the same terms and conditions as the usual sickness and accident disability benefit. At the present time there are many state court cases involving this question. I will mention one of these cases.

In Union Free School District No. 6 of the Towns of Islip and Smithtown, et al. v. New York State Human Rights Appeal Board, et al., 35 N.Y.2d 371, 362 N.Y.S.2d 139 (1974), the Court of Appeals, New York's highest court, upheld the position of the State Division of Human Rights. The school district was not subject to the Disability Benefits Law (which contains an exclusion for pregnancy disability), and its accrued sick leave plan did not allow an employee to use any sick leave if she was disabled as a result of pregnancy. All disabilities, except pregnancy, were covered under the plan. At the hearing before the Division of Human Rights the school district did not introduce any evidence pertaining to the costs of providing a pregnancy disability benefit. The Division of Human Rights held that the school district's practice of excluding a pregnancy disability from coverage under its accrued sick leave plan is prohibited by the State's Human Rights Law.

In this case the Court did not decide whether an employer that is subject to the Disability Benefits Law can exclude pregnancy from its disability plan for employees. Also, there remains the question whether significant cost factors can be used to justify such an exclusion.

Many insurance plans provide a flat payment for medical expenses related to pregnancy of an employee or an employee's spouse and generally pay a percentage of medical expenses arising from sickness or accident. Is such a practice discriminatory on the basis of sex? The EEOC's guidelines and the guidelines in most states are not clear in this area. In the only reported case that I am aware of, Satty v. Nashville Gas Co., 9 EPD 9919 (M.D.Tenn.1974), it was held that such practice is not discriminatory because female employees and wives of male employees receive equal benefits.

The guidelines of the EEOC and most state employment discrimination agencies provide that a female employee is entitled to maternity coverage if a wife of a male employee has such coverage under the plan. It is not clear if a female employee must have dependent coverage for her husband in order to be entitled to maternity coverage.

In the recent past many group insurance plans provided that only a male employee could insure his spouse. Today such a practice is considered to be unlawful. Under the guidelines of the EEOC and most state employment discrimination agencies, if a plan provides for dependent coverage of the spouse of an employee, it must provide such coverage without regard to the sex of the employee.

The standard Coordination of Benefits (COB) provision contained in many group insurance plans provides a simple method to determine which insurer pays first when there is overlapping coverage under medical expense plans issued to two employees. For example, a male and female are employed and their child is covered under the group insurance plan with their respective employers. Under the COB provision, when medical expenses are incurred on behalf of the child, the insurer covering the male as an employee will pay first and the insurer covering the female as an employee will generally pay the difference between the other insurer's payment and the actual expenses incurred. The parents receive full payment and no problem would appear to exist.

In a situation in which the parties are separated or divorced, a problem may be presented. For example, a child in the custody of the mother is hospitalized and the mother is required by the hospital to sign a form in which she agrees to pay the hospital expenses. Under the COB provision the father will generally receive most of the insurance payments and the mother may be left holding the bag if the father does not use his insurance payments to pay the hospital bill. This was the situation presented in a case involving a female employee of a large California employer and the EEOC took the position that the COB provision was discriminatory on the basis of sex.

The COB provision was intended to provide an easy-to-administer order of priority for payment and was not intended to be discriminatory on the basis of sex. However, it can create a problem in the type of situation mentioned above. It is suggested that consideration be given to amending the COB provision in order to eliminate the problem that may be presented when the parties are separated or divorced.

It is the position of the EEOC and most state agencies that male and female employees similarly situated (e.g., salary, years of service) are entitled to have the same amount of life insurance, and if the plan is contributory the premium payments made by these employees should be the same. This position does not prevent an insurer from using different premium rates based on the sex of the insured. However, in a contributory plan the employer would have to pay the difference between the male and female rates in order to equalize the contributory payments made by male and female employees similarly situated.

In Rosen v. Public Service Electric and Gas Co., 477 F.2d. 90 (3d Cir. 1973) it was held, in part, that under Title VII it is unlawful discrimination on the basis of sex to have a pension plan which allows women to retire with full benefits at a younger age than men can retire with full benefits.

On April 26, 1974 the EEOC rendered a decision (No. 74-118) in which it held that

> "any use of sex-segregated actuarial tables that results in payment of different periodic pension benefits to males and females is highly suspect. Because actuarial tables do not predict the length of any individual's life, any claim that such tables may be used to assure equal pension payments over a lifetime between males and females must fail. In order to achieve compliance with Section 703(a) of Title VII and with the Commission's Guidelines on Discrimination Because of Sex, the periodic pension benefits paid to males and females in equivalent circumstances must be equal. Moreover, it would not be a defense to Charging Party's charge that equalizing males' and females' periodic pension benefits would result in higher costs to Respondents, if indeed this were shown to be a fact."

The EEOC's position was upheld in Manhart, et al. v. City of Los Angeles Department of Water and Power, et al., 387 F. Supp. 980 (C.D. Calif. 1975). In this case the United States District Court held that it was unlawful under Title VII to require female employees to make larger monthly contributions than male employees in order to receive the same monthly retirement benefits as male employees. The defendent changed its retirement plan to provide for equal contributions and did not appeal the decision.

There are several pending cases in the federal courts involving the subject pension question, e.g., Spirt, et al. v. Teachers Insurance and Annuity Association and College Retirement Equities Fund (S.D.N.Y.).

It should be mentioned that the EEOC is not the only federal agency responsible for enforcing sex discrimination in employment provisions. Within the areas of their responsibility, the Wage and Hour Division of the Department of Labor, the Office of Federal Contract Compliance of the Department of Labor, and the Department of Health, Education and Welfare are responsible for enforcing such provisions. At the present time the EEOC is the only federal agency to hold that sex-segregated actuarial tables cannot be used in the fringe benefit plan area. The other agencies provide that a fringe benefit plan can provide either equal periodic benefits to members of each sex or equal contributions by the employer for members of each sex. President Ford has directed that a report recommending a single approach to resolve the inconsistent approaches among the agencies be prepared and sent to him.

On the state level, Robertson and Davis v. Riely, et al., Vanderburgh Circuit Court, Indiana (April 1975), is a significant court case in the area of group pensions. In this case it was held that the use of the 1971 Group Annuity Mortality Table, which results in the payment of greater monthly annuities to men than comparable women, is arbitrary and discriminatory and in violation of Article 1, Section 23, of the Constitution of Indiana guaranteeing the equal granting of privileges to all citizens. Also such use is in violation of the Equal Protection Clause of the 14th Amendment to the Constitution of the United States.

In summary, the final interpretation of Title VII and similar legislation will be made by the courts. If legislators do not like the interpretation, they will probably pass specific amendments which reflect their intentions.

During the last three years lawsuits have been instituted against the insurance commissioners of such states as California, New York and Pennsylvania. In these suits the plaintiffs have alleged that the commissioners were and are aiding, abetting and conspiring with insurers in discriminating against women in violation of constitutional and statutory rights.

Since the institution of these suits, many state insurance departments (e.g., Michigan, Missouri, New Jersey, New York, North Carolina and Pennsylvania) have sent voluminous questionnaires to insurers requesting information pertaining to sex discrimination in insurance. Several of these departments have published reports regarding their findings of discriminatory practices by insurers.

Several states have enacted statutes, or insurance departments have promulgated or proposed regulations, which prohibit insurers from discriminating in availability and coverage on the basis of sex. These states include Arkansas, California, Colorado, Kentucky, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, Utah and Washington. On the federal level, there are several bills (e.g., H.R. 4354) pending in the House of Representatives which would prohibit insurers from discriminating in availability and coverage on the basis of sex or marital status.

Under these statutes or regulations, insurers are required to have policy forms which are equally available to males and females. Conditions which are peculiar to one sex cannot be excluded or coverage limited thereon in a manner which is inconsistent with the coverage of other conditions and sickness under the policy. In most instances, complications of pregnancy are required to be covered on the same basis as a sickness. For underwriting purposes, men and women must be treated equally. A frequently-cited practice which the departments consider discriminatory is a requirement that a woman take a physical examination when a man is not required to do so.

Any discussion of sex discrimination in insurance is not complete without dealing with premium rates. It has been alleged that women are being unfairly discriminated against because they are charged a higher premium than men for medical expense coverage, disability insurance and annuities. As for life insurance, it is claimed that women are often required to pay too much for this coverage. For example, it is said that the practice of charging a woman a premium as if she were a male three years younger than her actual age does not reflect the true difference between male and female mortality.

Are the above-mentioned allegations justified? The morbidity data indicates that the average claim costs of females are higher than those of males. The mortality data for annuities indicates that females, on the average, live approximately 6 or 7 years longer than males. The data appears to support the general practice of charging females a higher premium than males for medical expense coverage, disability insurance and annuities. However, whether a specific premium rate for a particular coverage for females is justified and supportable can be determined only by examining the data used in calculating the premium.

As for the use of the three year age setback to calculate life insurance premiums for females, at the time this method was adopted by some insurers it was considered to be one of several possible approximations that could be used

to determine a proper premium. This method had the virtue of simplicity, was reasonably accurate, and it tied in with the valuation and non-forfeiture laws in many states. Some actuaries have advised me that recent trends indicate a widening in the male-female mortality gap. If this is in fact the case, it suggests the possible use of a longer setback or the use of separate male and female mortality tables for life insurance.

In the employment area the EEOC, some state discrimination enforcement agencies, and a few courts have required that males and females of the same age pay the same premium for fringe benefits. However, this matter has not been determined by the highest courts in the jurisdictions involved.

As previously mentioned, there are several bills pending in the United States House of Representatives which would prohibit an insurer from discriminating in availability and coverage on the basis of sex or marital status. All of these bills specifically state that rates, supported by relevant actuarial data, may differ with respect to the sex or marital status of the insured.

I am not aware of any insurance laws or regulations which require identical premium rates for males and females. However, the insurance departments in many states are taking a long and hard look at the premium rate structure in this area. In order to justify different rates based on sex, insurers must be prepared to demonstrate that such differences are based on sound actuarial principles supported by credible data.

Several states (e.g., California, Colorado, New Jersey, New York, Oregon, Pennsylvania and Washington), in addition to prohibiting discrimination on the basis of sex, prohibit discrimination on the basis of marital status. Some people I have talked to have expressed the concern that these statutes appear to require insurers to issue a family policy to people simply living in the same house, friends, etc. I disagree with such an interpretation of these statutes. In my opinion, these statutes simply require that insurers do not discriminate against an individual because of marital status. An example of such a discriminatory practice would be an insurer's uniform practice of refusing to issue an individual life or disability policy to single or divorced persons.

It appears to be a certainty that in the immediate future most, if not all, states will have sex and marital status discrimination statutes or regulations. In most instances it should not be very difficult for insurers to adapt to them.

I will now highlight some of the recently enacted legislation in the area of discrimination in insurance based on mental or physical handicap. That is, in some states insurers are required to issue a policy of insurance to a medically-impaired individual.

One of the first states to pass this kind of legislation was Massachusetts. In 1972 a statute (Annotated Laws of Massachusetts, C.175, Sec. 120A) was enacted which provides that life insurers cannot refuse to issue a $1,500 policy on the life of a minor "for the sole reason of mental retardation." In 1974, statutes (Annotated Laws of Massachusetts, C.175, Sec. 108A and 120B) were enacted in that state which provide that insurers cannot refuse to issue policies of life, accident and sickness insurance "for the sole reason of blindness." All of these statutes do not provide for any adjustment in the standard premium for the policy applied for.

In 1974 a statute (Revised Code Washington 49.60.030) was enacted in Washington which prohibits discrimination in availability and coverage because of sensory, mental or physical handicap. Insurers are allowed to charge an appropriate premium for handicapped individuals. (Washington Attorney General Opinion AGLO 1974 No. 100-November 26, 1974)

This year several states enacted legislation in this area.

Florida - The statute (Senate Bill 664) provides that an insurer cannot refuse to issue or renew a life or disability insurance policy "solely on the grounds that the applicant or policyholder suffers from a severe disability." The term "severe disability" is defined as a spinal cord injury or disease resulting in total and permanent disability, amputation of any extremity that requires prosthesis, and blindness. This statute appears to allow an insurer to charge an appropriate premium for the coverage.

Maine - The statute (House Bill No. 846) provides that an insurer cannot cancel, reduce limits, increase the premiums, or refuse to issue or renew a policy of any kind for the "sole reason" the applicant or insured is blind.

Minnesota - The statute (Senate Bill 765) prohibits an insurer from rejecting an individual's application for life, accident or health insurance, as well as determining a rate class for such individual, because of disability, "unless the claims experience and actuarial projections and other data establish significant and substantial differences in class rates because of the disability."

North Carolina - The statutes (House Bills 475 and 476) prohibit an insurer from refusing to issue a life, accident or health insurance policy, or charging a higher premium therefor, "by reason of the fact that the person to be insured possesses Sickle Cell Trait."

There is a proposed regulation in at least one state (Pennsylvania) which would require coverage of medically-impaired individuals. Taking into consideration the existing and developing attitudes regarding availability of insurance coverage for all individuals, it is highly probable that during the next few years we will see more and more of this kind of legislation and regulation.

Some of the statutes mentioned above require that the medically-impaired risk be insured at a standard premium rate. Other statutes allow an insurer to charge an appropriate premium for the coverage. I believe that the Minnesota statute contains the basic criteria many insurance departments will employ in determining whether a premium can be supported as being "appropriate." This statute provides that an insurer cannot use a substandard rate for a medically-impaired individual "unless the claims experience and actuarial projections and other data establish significant and substantial differences in class rates because of the disability." If insurers do not have such claims experience and data, it is imperative that they be compiled as soon as it is reasonably possible to do so. Without such supporting documentation, insurers will not be allowed to charge other than a standard premium to a medically-impaired individual.

In conclusion, we are in a period of changing ideas and standards and the insurance industry must take a good hard look at itself, evaluate its practices and, if any such practices are unfair and cannot be supported, make appropriate changes before such changes are forced upon it by legislators and regulators. I do not mean to imply that the industry should voluntarily make changes that are not warranted by credible data or sound judgment. Also, I believe that proposed legislation or regulation which is contrary to such data and sound judgment should be opposed within reasonable limits.

MR. DARRELL D. EICHHOFF*: Throughout my career in the insurance business, I have had responsibilities in both marketing and administrative areas. Service to policyholders is usually associated with these areas, so I suppose I have some qualifications to speak about improvement in service to policyholders. I especially welcome this opportunity to talk about service to a group of actuaries because it gives me an opportunity to expound on one of my favorite themes. The theme is that responsibility for service is first and foremost a corporate responsibility. The actuary, the doctor, the lawyer, the accountant, the investment expert - these, and all other specialists in our industry, have an important share in the corporate responsibility - to provide quality service promptly and economically to our customers.

Our industry traditionally has attempted to respond positively to consumer challenges by engaging in self-examination and self-correction. In the face of increasing demands for better service, several of our trade associations came to the conclusion about two years ago that they could serve a useful purpose by cooperatively developing suggestions for specific activities that individual companies might adopt to enhance their efforts. Obviously, the sum total of improvement in service to policyholders that is made by all companies contributes to the enhancement of the industry's image in the eyes of the customer.

So the LOMA/LIMRA Customer Service Committee was formed, and I was asked to serve as its Chairman. Forming the Committee under the combined aegis of an organization with a traditional focus on Home Office functions (LOMA) and the other on marketing functions (LIMRA) was, in itself, a constructive move.

The Committee's first activity was to agree on two basic premises - that customer service is a corporate responsibility, and that each company should delegate this responsibility as it sees fit. Then it was decided to limit the range of areas to be explored so that adequate progress could be made in some key service-related areas. It wasn't surprising to me that, as the Committee's deliberations proceeded, it was discovered that improvement in service touched on almost every area of company activity.

The Committee aimed at improvement in service to and through three separate groups:

- Those for whom social needs are fulfilled - both present and potential customers, and beneficiaries;

- Those who fulfill these social needs - individual companies, and their Home Office and sales forces;

- Those who monitor the industry - legislators, regulators, and consumerists.

For the first group, customers and beneficiaries, proposals were developed to assist companies in providing an understanding of product, price, and services available, both at and following the time of purchase. For the second group, the proposals concerned ways that would help Home Office and Field personnel to work together better to serve the "outside" publics. Finally, various actions were proposed through which our relationships with industry monitors could be improved.

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Just last month, summaries of eighteen action proposals finalized by the Committee were released to the member companies for their consideration. The ultimate responsibility for service rests with the individual companies. Each company must decide what services will be provided and what means will be used in their respective organizations to provide those services.

Where does the effort go from here? An obvious avenue is the maintenance of cooperative concern over improved service as an ongoing policy. It is hoped that the Boards of both LOMA and LIMRA will see the value of establishing a permanent monitoring mechanism to measure and evaluate progress in implementing the recommendations of the Committee. Such a mechanism should involve the entire industry by having the endorsement and support of all our major trade associations and their member companies, and the NAIC as well. The trend toward united efforts by all of our trade associations is most encouraging to me, for I see in this trend a more effective means to answering the critics of our industry.

It is appropriate to mention here another Committee with similar interests, the Consumer Affairs Committee of the Institute of Life Insurance, which was formed a few years ago. This Committee is empowered by the Board of the Institute of Life Insurance to work for the correction of consumer misunderstandings of life insurance, and for the fulfillment of consumer expectations concerning the service of life insurance companies. It is my personal belief that these two Committees compliment each other's efforts.

In completing the first phase of its activities, the LOMA/LIMRA Committee has not created a series of remarkable new solutions to continuing problems. It did create, however, a reasoned, ordered set of action proposals which can, as adopted by the companies, effect tangible improvements in customer service. The thrust of each action proposal is toward encouraging companies to examine their present practices and, to the extent such practices are not in accord with the proposals, to move toward uniform adoption of the actions suggested. Thus, the Committee hopes that its work can serve as a catalyst for continuing self-examination and self-correction.

The action proposals concerning the policyholder and beneficiary public are perhaps of most immediate interest to you. Some of these directly concern activities related to actuarial work. For example:

- Improving contract readability and furnishing supplementary material explaining contract terms;

- Providing information at issue about available services;

- Giving policy cost comparison information;

- Providing for a 10-day free examination period for new policies;

- Providing more useful information at key points during the life of a policy when policyholder action may be desirable;

- Adopting uniform death claim forms and consistent claims practices such as return of premiums paid beyond the date of death and payment of interest from the date of death.

Each of us is familiar with the continuing discussion as to which is the most important factor in achieving a sale of a policy - the salesman, the company, or the policy itself. I'm inclined to think it's not the policy, although perhaps I'm personally influenced because of my own sales experience.

Be that as it may, it's unfortunate that the contract representing the financial services our companies are offering, our salesmen are selling, and our insureds are buying can't be more readily understood. Real progress is being made despite the legal and regulatory restraints under which we operate in the area of policy design and language.

Perhaps some companies feel that they have achieved an irreducible level of technical language, but I don't think I'm alone in believing that very few have achieved an ultimate level of clarity, either in phraseology or design. On the other hand, I'm not overly impressed with the arguments of those who would rank a policy contract's readability far more difficult than, for example, the Bible's. Even scholars frequently disagree on the meaning of a given book, chapter, or verse of the Bible.

Nevertheless, we must deal with the realities of our era. It is in our own best interests, working within the constraints of the laws, the courts, the regulatory bodies and our own attorneys, to produce a contract which is as understandable as possible, and to supplement it with whatever explanatory material is necessary.

The latest draft of the NAIC regulation on life insurance disclosure and cost comparison aims at a better-informed insurance buyer. Specifically, Section 4(b) of the regulation requires giving to the prospective purchaser explanations of:

- The three basic types of insurance and their common uses;
- Participating and non-participating policies, and stock and mutual companies;
- Non-forfeiture benefits;
- How to determine the needs for life insurance;
- How to compare relative costs of life insurance policies.

The Customer Service Committee has recommended to the LOMA and LIMRA member companies several items in this regard:

- That the new policyholder be presented at issue with an explanatory booklet clarifying certain rights of the policyholder, perhaps including a glossary of key terms as well as a statement of detailed company plans for the provision of good service;
- That they participate in the activities of an Intra-Industry Review Committee, which will be formed to review and publish, through the trade associations, suggested "readable" policies;

> That they consider developing or revising cost comparison information (for policyholders requesting such information) that is consistent with the positions of the ALIA, CLIA, and NALU, and they make available to policyholders and prospective purchasers brochures explaining cost comparison methods.

In brief, the position of each of the trade associations just mentioned is that cost data should be available on request; that the interest-adjusted index is the most practical method developed so far, even though it is inappropriate for comparing unlike policies; and that the interest-adjusted index should not be construed as a basis for measuring the true cost of a policy.

I think it is clear that the industry as a whole fully supports the concept of consumer education. Consumers are entitled to as much information as they wish in order to purchase and maintain an insurance program that will best meet their individual needs. But the importance of competitive costs cannot be over-emphasized. We can best serve by actively seeking responsible and uniform regulations which retain for the individual companies prudent initiative in supplying this information.

Until recently, "Reports to Policyholders" usually identified the typical end-of-year balance sheet, income statement, and summary of significant actions taken by a company during the year. Now, however, a different kind of report to policyholders is being proposed in Senator Hart's pending bill titled "Consumer Insurance Information and Fairness Act." Some of the troublesome portions of the proposed bill have to do with the periodic reporting of policy values and policy cost data. My comments on this subject will be very brief since Mr. Munson will be covering it in more detail.

Our industry should, I believe, agree with Senator Hart that our goal is better consumer education. But it also should be clear that it is quite possible for efforts in this area to be counter-productive. It is very likely that an array of numerical and narrative data given on a mandated basis will become technical, cumbersome, confusing, and, most important, inordinately expensive. If data called for in the Hart bill are misunderstood, the goal of better consumer education would certainly not be achieved. If the cost of life insurance would be significantly increased by the requirement for providing summarized data of questionable value and validity year after year, are the best interests of the insurance buying public being served?

This question leads me to my next general topic - the cost impact of service. During the past ten years, while the consumer price index was growing by slightly more than 4½ percent, Home and Field Office expenses, excluding commissions, expanded at twice that rate. This fact and its implications are, I feel, the most challenging problems facing our industry.

Living in an era in which we, at times, have to deal with double-digit inflation coupled with so many sectors examining our actions, it is mandatory that we pay close attention to the relative costs of the service we, as individual companies and as an industry, provide. Many feel a 6 percent rate of inflation over the next ten years is a distinct probability. Based upon relationships of the past decade, this could translate into a 12 percent annual rate of increase in Home Office and Field expenses. We cannot allow these expenses to keep edging up faster than our premium income. We operate in a highly competitive business and the net cost of our product will be more and more important in the years ahead. Therefore, we must continue striving for ways to improve our productivity without impairing service to policyholders.

It would be simple to sit back and say that after the sale the only service we should provide is that which is called for by the policy contract - the payment due at claim, maturity, or surrender. Of course, the satisfaction that would come from this escape from reality would not last long.

The concept of service in the insurance industry is a broad one and involves not only the nature of the product line, the soundness of pricing, the competence and integrity of the field force, the soundness of the investment policy, and the efficient carrying out of contractual obligations, but also the Company's over-all responsibility in dealing fairly with all its publics and being a corporate citizen with great integrity.

The clearest service responsibility we have is to our ultimate customers - our policyholders and their beneficiaries - the persons we insure and all those persons who look to us for fulfillment of the contract. The basic need is to provide the means to satisfy the contractual obligations we assume on sale. However, aside from the mandatory nature of this service, it must be viewed as an opportunity for an individual company to maintain the necessary level of confidence that will inspire the insured to accept that company for satisfying future insurance needs. We also have a responsibility to serve the entire prospective insurance-owning public by developing a portfolio to fit their needs and to provide means for them to better understand our product.

There are many avenues open to us to improve the opinions of our current customers, our prospective customers, and/or our critics. Some actions, for example, can be taken to lower costs without causing an overt change in service. We can do something about personnel turnover. We can do something about productivity. These are essentially internal management situations. We can do something about the average size issue. To the extent this increases the average amount of insurance owned, this is good for our image. And, of course, the effect on the cost index is beneficial. We can do something about lapse rates, to the direct benefit of all.

In a great number of situations, however, we must be aware of the direct relationship between the cost of a particular service action and the benefit which might be gained by the insured or the company. We must ask ourselves how much service is enough and whether we have to lead the industry in the level and variations of service we are capable of providing. This is a difficult question and each individual company must try to answer it within the context of its own situation, philosophy, and goals.

It is up to each of us to determine the point at which we strike the balance between service costs and the resulting benefits. It should be remembered, however, that, as disassociated as some of us may seem to be from the marketing aspect of our business, we are essentially a marketing organization. We must have a clear focus on our markets and be prepared to furnish the type of service that will enable our sales forces to operate successfully in those markets.

The past few years have been challenging and exciting, and at times even traumatic for our industry. Looking to the future, we must expect even greater challenges. To meet them, we must conscientiously determine our goals and act toward their fulfillment in a level-headed, business-like manner, doing our best to justify our actions before we take them, so as to be better able to explain them to those who may question them - including ourselves.

MR. WILLIAM F. SUTTON, III: I'll start out this afternoon by giving you a little information about the context from which I will make my remarks. This will help you, perhaps, understand why I say what I do. On the other hand, it might better help you to form a basis to disagree with me. In any event, I am the chief actuary of a large, United States mutual company which puts a great deal of stock in its mutuality. We constantly remind ourselves of our duties to our policyowners and the fact that it is really they for whom we are working.

Within our actuarial staff, we strive to have a highly professional approach to our work. This is particularly so in the matter of dividend determination. Also, I am fortunate to have as my chief dividend architect an actuary who has been very active in our education and examination structure. When reviewing dividend questions, he gets into philosophical discussions which make very interesting conversations when he returns.

The reference "Munson Report" for the first part of my topic refers to the booklet titled "Philosophies in the Computation and Dissemination of Dividend Illustrations" prepared by the Society of Actuaries Committee on Cost Comparison Methods and Related Issues (Special), which was chaired by Bart Munson, my fellow panelist. This booklet was first made available at our annual meeting in New Orleans last year.

In preparing for this assignment, as I reread the report, and particularly the chapter titled "Dividend Philosophies," I generally felt pretty good about what actuaries were saying concerning their dividend philosophies. One statement made in the report was, "...where firmly established philosophies were reported by the respondents, they generally adhered to traditional actuarial theories." At another point, the statement is made, "It would appear that, for the most part, 'dividend philosophies' are fairly consistent from one company to another." Where there were not established dividend philosophies, I wonder if the Committee could go back to its basic data and determine whether this situation exists in a homogeneous or heterogeneous group of respondents.

I firmly believe that dividends should be calculated with greatest possible equity between various classes of policies no matter whether they are recent issues or policies which have been on the books for 40 years or more. It was heartening to see that in the Munson Report there is a fairly consistent body of actuarial opinion feeling the same way. Nevertheless, there were responses from actuaries of 23 companies, 8 of 45 mutual companies and 15 of 42 stock companies, who indicated by their replies that no firm philosophy existed, or, if it did, that they were not entirely satisfied with it. This is too bad. All of us actuaries, perhaps some more than others, who are employed by companies have some potential conflict between our loyalties to our employers and our concerns for the policyowners whom we serve. I believe that our company and professional loyalties can coexist. If our managements are not in tune with proper actuarial concepts of equity, we have an obligation to educate them.

I looked at the Best's Review Statistical Study where, for policies issued in 1954, a comparison was made of the dividends illustrated at the time of sale with actual dividend history. Out of 66 companies in the study, I found three that had made very few changes over the years. One of them maintained its 1954 dividend scale without change for 13 years. Another went 15 years, and the third one never changed its dividend scale.

I looked up the descriptions of these three companies and was somewhat surprised, and a little disturbed, to find that the two companies that went longest without changing their dividend scales were mutual companies. I find that

fact very difficult to understand. If policyowner interests are to be fully considered, I can find no basis of dividend philosophy, as I have ever seen it described, which would permit such action unless the experience of these three companies was markedly different from that of the other 66 companies in the study. Somehow, I find that idea difficult to grasp. It does not seem to me that such business can truly be called participating.

I can't escape the feeling that most companies offering both participating and non-participating insurance do so primarily for sales purposes. Apparently, their agents in some situations have to have a participating product to compete with other participating products. That says something for mutual companies, but I am not sure what.

I am aware that some stock companies have a rather complete segregation of accounts between participating and non-participating business. Also, some have restrictions on the amounts of profits that can be retained for stockholders from participating business. I sense that actuaries in most of these companies approach the matter of dividend determination in much the same fashion as actuaries of mutual companies.

Nevertheless, I have to raise a question. Basic experience factors being equal, is a policyowner really as well off buying a participating policy from a stock company as he is buying from a mutual company, considering the fact that some profit for stockholders must come off the top of the stock companies' participating business? While the stockholders may share some of the ultimate risk for the participating policyowners, aren't the profit charges and the amounts necessary to provide the participating policyowner's surplus greater than the normal mutual company contingency requirements?

I have the impression that some stock companies' participating policies are really non-participating policies with the dividends built into the premium calculation as a benefit with little expectation of future change. Another question I throw out for discussion is whether a policyowner really benefits from this kind of participating business. Should we have some name for it other than "participating"?

Another Best's Review study in a recent issue compared ten year dividend histories with 1965 illustrations for 72 companies. Of seven companies making no change from the original illustrations, six were stock and one was mutual. Of three companies paying lower dividends than illustrated, two were mutual and the third is a stock company that seems to operate on a mutual basis. This strengthens my feeling that some stock companies' participating policies do not really reflect experience through dividend changes.

I would sum up the first two parts of my discussion by saying that the only true participating insurance is that where the policyowner's interests are paramount in dividend determination. Changes in experience factors are regularly considered. Further, a great deal of consideration is given to equity between classes. No policy, whether written by a mutual company or a stock company, in which dividends are just another benefit, meets this definition.

To the actuaries of those 23 companies previously referred to who admitted, sometimes with regret, they have no real dividend philosophy, I make a plea to develop one. We have a professional obligation to distribute our dividends under some reasonable and consistent philosophy. In today's environment, cavalier attention to dividends invites consumerist criticism and government interference. At the same time, court decisions on dividends give companies a great deal of discretion in dividend determination.

I feel the question of illustrative dividends versus those that are actually going to be paid is becoming a greater matter for concern. Some 16 to 18 years ago, I had to answer letters from policyowners who questioned the amount of dividend accumulations on their policies. Back in the early thirties, a policyowner might have purchased a retirement income policy providing $100 monthly income at age 65. At the time of purchase, that individual probably thought he would live like a king on $100 monthly retirement income. The situation was even better, because he got an illustration which showed that the accumulated dividends might add another $20 a month, so he would be receiving the princely sum of $120 each month as he relaxed and played with his grandchildren.

Then, in the late fifties, at the time the policy matured, our policyowner would find out that he had a total income of $103.27 - $100 guaranteed and only $3.27 from dividend accumulations. He was looking for $120, of course. So, he wrote in and asked us, "How come?" The basic problem was that, beginning in the 1930's, companies went through a decade or so of reducing their dividend scales about as often as they increased them during a similar period in the late fifties and early sixties. In between, with the record low interest rates of the 1940's, dividends were at a generally low level.

I often wondered how the actuaries of the 1930's rationalized the current year's dividend illustrations which they knew would not hold up the next year. Now, I'm wondering how soon I might be facing a similar situation. The problem today, of course, is the fact that expenses have been increasing at great rates and, measured in dollars, are coming close to overtaking the rate of growth in investment earnings. For a period of twenty years or more, we were greatly helped in establishing our dividend scales by the steadily rising interest rates. Interest rates are still going up, but the effect of inflation on expenses now tends to offset the investment growth. The combined effect will tend to limit increases in amounts of dividends that can be paid out.

In our studies of the theory of surplus distribution for the actuarial examinations, we learn all about equity between classes of policyowners, methods of computation, determination of the amounts of divisible surplus, and the like. However, there is always another important point. That is, our policyowners have expectations as to what dividends should be like. An actuary should never lose sight of this point. In actual practice, it can be significant but, of course, never overriding considerations of equity.

While I have seen some evidence recently that indicates people don't really compare their illustrations to the dividends they receive, I feel that, particularly in the early years after a policy is sold, we are likely to be checked up on to some extent. After all, it doesn't take very many policyowners with sharp pencils to write in and keep a correspondent quite busy writing about dividends. Yet, these same sharp-pencil correspondents wouldn't be a significant number in a study of policyowner attitudes.

Getting back to the current situation, we generally have steadily rising income which is sufficient to cover the growth in our dividend payouts. However, with respect to individual dividends, the incidence of the effect of higher expense rates is much different from the incidence of the effect of improved interest earnings. A whole life policy issued at a young age just doesn't build up reserves at a fast enough rate to gain very much from added excess interest. The reduction in dividends from higher expense is likely to be greater than the increase from interest for as long as twenty years or more. Thus, even though we might be able to increase slightly the total amount of dividends payable

under a new scale for a particular year, it is quite possible that we would find some dividends we are paying under the new scale are less than those we illustrated in the previous year's rate book.

Concern for policyowners does not dictate that we must pay no less than we have illustrated. I believe we can live with some small downward revisions in individual dividends. Also, there are techniques for minimizing the effect of some changes.

In my company, we use two procedures which are practical under current conditions - freezing and pegging. We will always pay at least the same first year dividend we have illustrated, even though our new formulas would say the dividend should be lower. Thus, we have "frozen" the first year dividend. Also, we will not pay a lower dividend in any year than was paid in the immediately preceding year. This "pegs" a current dividend to the same level as last year when new formulas would dictate a lower value. These practices add a mere fraction of a percent to the amount of our dividend payout. We feel basic equity is maintained and the public relations value can be considerable. These procedures work with the kind of changes we have been experiencing in our dividend scale factors the past few years. However, they do not apply if a drastic downward revision in dividend scales would be necessary.

I feel in general that actuaries have to be concerned whether the current margins for dividends we have in our present products will last into the future. I have seen no prediction of any end to inflation. To be sure we can expect some relief from the high levels recently experienced. However, much of what I read talks about a continued level of five to six percent rather than the two to three percent that applied for many years. This means continued pressures on our unit costs.

Interest rates are likely to remain high, although new money rates are likely to be a little lower than in the past year or two. The actual growth in our portfolio rates is going to be slower as the rate on our portfolio approaches new money rates.

From a combination of these two factors, I speculate that within the foreseeable future we have to be concerned that our growth in net income will diminish and our ability to pay dividends comparable to those paid today will be affected.

In the past, we have had substantially improving mortality gains. We all know there has not been any significant change in the level of mortality for a number of years, even though the trend is still downward. In our consideration of the future, we just cannot assume there will be any break-through in mortality to give us added margins.

Considering current pressures on our net income and surplus, I believe that there is a real possibility that within five years or so we could be in a position of having to decrease the amounts of dividends we pay to our policyowners. There is a real question as to what we will do about dividend illustrations when we know the next dividend change will be downward. I don't have any good answers to that question. However, maybe I can say a few things that will generate some discussion.

There was a chapter in the Munson Report concerning opinions regarding the likelihood of payment of illustrated scales. I am in the minority of respondents to one question which the Munson Committee asked on this topic. I feel

current dividend illustrations are just what their name implies - dividends illustrated on the current scale. However, there is a good body of opinion which feels our dividends should actually be projections of expected results, rather than illustrations based on current experience. As given in the Munson Report, some 65% of the total respondents expressed interest in the use of dividend projections.

I'm not ready to join that bandwagon yet. We have to work within an existing body of state laws and regulations. I can see as many problems with changing those regulations to allow projections of dividends as we have with the current system. I doubt that ten years ago there would have been as much interest in the projecting of dividends as there is today. I feel we should operate under the same general practices on both the up side and the down side of dividend changes. At the same time, I should make it clear I don't feel we have to be locked into our present procedures.

When we got those complaint letters about the retirement income dividends, it was always good to get a copy of an illustration where the agent had properly qualified the figures involving dividends with asterisks and footnotes to make it clear they were not guaranteed. Today, I feel with most of our illustrations being computer prepared, we probably do a better job than at many times in the past at printing the proper caveats on our illustrations. These caveats may help us avoid some lawsuits. However, I don't feel we can hide behind them when we have a good expectation of not being able to pay our illustrated dividends.

If the day comes when we have to make drastic reductions in the amounts we distribute in our dividend scales, we must communicate the situation to our prospects and policyowners in some way. For those of our policyowners with in-force policies, it would be necessary to communicate with them in some way as to what is happening. For new prospects I would suggest that we limit the number of dividends which we illustrate and make it clear that it is very likely future dividends will be lower than the amounts shown.

I can't be sure I could sell this concept to my friends on the marketing side of our company. However, unless your discussion of this topic comes up with something that strikes me better, I would sure try.

MR BARTLEY L. MUNSON: I don't have to start with the usual disclaimer that anything I might say does not reflect the opinions of my committee, for the committee was discharged as of Sunday. Anything I might say now is totally my own opinion, and there shouldn't be any doubt about that.

People do hold different opinions about the cost comparison and disclosure subject, but I think we would all agree that what it's all about, or at least we would hope it should be about, is to get more useful information to the life insurance buyer. I thought we would start today by looking at a few characteristics that I have selected from some surveys that tell us a little bit about that buyer as they relate to this subject. If these have not been totally randomly selected, and they haven't, they are in no particular order; and they are certainly not the only, let alone the most significant, items that we could identify from some of these surveys. I think, though, they do give us a sampling of various characteristics about the buyer, against which we could see what both federal and state people are doing. I will list seven of them very quickly.

First, over half of the life insurance buyers consider themselves not very well informed, or not informed at all, about life insurance.

Secondly, 50% of the public believes there are cost differences among life insurance companies and policies; the other half doesn't think there are any differences.

Third, about half of the public believes there are differences in the content of life insurance policies. The other half thinks they are all the same.

Fourth, in the Insititue of Life Insurance's 1972 Monitoring Attitudes of the Public (or MAP) survey, consumers were asked to describe in their own words the differences between term and whole life insurance. In spite of the fact that these two forms of insurance are almost self-defining, approximately 1/3 of the respondents would not venture a guess and another 10% gave answers which are universally true about all life insurance.

Fifth, a 1954 survey showed only 7% of the potential buying public could correctly define par and non-par policies. In 1975, another showed only 17% of male household heads between ages 25 and 50 could correctly define a par contract.

Sixth, 77% of the buyers believe that the agent's recommendations are affected directly by his commission system.

Seventh, according to a recent survey, 60% of the buying public said they had a lot or some difficulty in determining whether they were getting their money's worth in life insurance.

The writer of a lengthy article in last month's Forbes magazine made what I thought was an interesting statement: "Comparison shopping for life insurance policies requires a degree of patience (masochism?) and a fondness for mathematics well beyond normal human capacity." Based on these and many other examples we could offer, I hope we would all agree there are things that we could do and that we should do to improve the quality of information to that life insurance buyer.

Now, others have been doing something about it. In my opinion, it has not always been constructive or well thought out and, regretably, too much of what has been done, particularly on a self-initiated basis, has not been done by those within the insurance industry or the actuarial profession. We won't review the long list of things that have been done on a widespread and increasingly frequent basis in the past several years. It is most useful to review the two significant items that pretty much tell where it's all at right now. I am referring first to the current draft of the NAIC proposed model regulation, and secondly to the Hart bill that Darrell referred to earlier, which was introduced in July. I would like to briefly analyze both of these, starting with the NAIC proposed model regulation.

As you know, there has been considerable activity on the NAIC front for the past several years. The 12 research projects that they initiated have now been completed and published. If you haven't read them, you may wish to write to the authors or to the NAIC office in Milwaukee and get a copy.

It appears to me that maybe the three strongest messages that are coming across to the NAIC from these research projects, judging by their present drafted model regulation, are these: 1. The subject of life insurance disclosure and cost comparison is a difficult one to find practical and generally agreed-upon answers to. It's no surprise to many of us, but I think that message has come across pretty strongly. 2. Disclosure of basic information has increased in relative importance when compared to the actual strict cost comparison issue. I believe that is fortunate. 3. The Interest-Adjusted method is the best method to use for cost comparisons, all things considered.

The draft of a regulation which they hope to adopt this December to replace the interim regulation was circulated in June. A redraft of that was mailed by the NAIC task force last Friday. In this redraft they have made some obvious attempts at accommodating the various reasonable concerns that different people have shared with the NAIC in the past few months. In my opinion, they have done a pretty good job of it.

The second section of the redraft relates to what they call the "Purpose" of the regulation, and I would like to read a sentence from that. "The purpose of this regulation is to require insurers to deliver to purchasers of life insurance information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration, and improve the ability of the buyer to evaluate the relative costs of similiar plans of life insurance."

While the redrafted proposed model regulation is 21 pages long, I should point out that 10 pages of that are an example of what the regulation calls a "Buyer's Guide" to be given to prospective purchasers. Somewhat related to an item that Darrell referred to earlier, they define a document which contains, and is limited to, specified language or alternate language approved by the insurance commissioner. It starts with a two sentence introduction: "The following information is designed to assist you with the difficult task of shopping for an appropriate life insurance policy. It is intended to present in an orderly fashion what might otherwise appear to be a confusing array of choices." I suspect that this wording will come in for considerable discussion in the next month. The Buyer's Guide goes on to discuss the basic types of life insurance, fixed-cost versus participating policies, types of insurance companies, determining the need for life insurance, and how to compare relative costs of life insurance policies.

I would like to read a paragraph from this part of the Buyer's Guide, for it is a pretty good explanation of how to use an index. It says in part: "If all policies contained the same cash values and if all policies were either fixed-cost or participating with identical dividend scales, it would be necessary only to compare the premiums of two policies to determine which policy offered the lower cost. Since most policies do contain different cash values and since some policies are fixed-cost while others are participating with a multitude of dividend scales," or dividend philosophies as you might add, Bill, "the simple comparison of premiums is not sufficient to disclose the lowest cost policy. Since it is extremely difficult to evaluate the differences in premiums, cash values, and dividends, a set of indexes has been developed to assist you in comparing policy cost. Each index combines many premiums and dividends and a cash value into one index number. They are designed to give more credit for money paid or received today than money paid or received in the future. Although these indexes will help you compare the cost of life insurance policies, an index alone is not enough information on which to base your purchase decision.

You should consider the pattern of premiums, cash values, dividends, and death benefits from which the cost index was calculated. You should also consider the financial strength of the insurance company and the ability of the insurance company to provide service to you as a policyholder." There are several other paragraphs related to indexes, but I felt those were fairly key in this particular part of the guide.

The drafted proposed model regulation requires, in addition to the Buyer's Guide, that there will be a "Policy Summary," which is what most of us might call a ledger statement. This Policy Summary would also include the surrender and net payment indexes. This Policy Summary can be either a separate document or a specifications page in the policy. The NAIC thus has accommodated the concern about merely repeating what's already in the contract on another page.

The regulation would require that the insurer shall provide a Buyer's Guide and a Policy Summary within a reasonable time following a request therefor. If the company has a 10-day free look, the information can be given at the time of delivery of the policy. Without a free look, both the Buyer's Guide and the Policy Summary must be given prior to writing the application.

There is one provision that says: "Any illustrated dividends used in calculating the indexes shall be the current scale in actual use by the insurer." An interesting point.

It forbids comparing costs by any method that does not use the time value of money. It does say, however, that a system without the time value of money may be used for the purpose of demonstrating the cash flow pattern of a policy, if such presentation is accompanied by a statement disclosing that the presentation does not recognize the time value of money, and provided the presentation also includes a Buyer's Guide and a Policy Summary.

The drafted regulation asks that we compare only two or more similar policies. In my opinion, not only should we not use the Interest-Adjusted method for comparing dissimiliar policies, we should not use any other method either. Comparisons of costs simply isn't the appropriate place to start when you are looking at two different, dissimiliar policies.

There is a meeting called for this subject on November 17 in St. Louis. It is a public meeting, to be followed the next day by an executive session of the NAIC task force. The intent is to adopt this or a modified version at the December NAIC meeting. The NAIC would appreciate written comments from anybody by November 12, if possible. Both written and oral comments are welcome on November 17 in St. Louis. The last sentence of the cover letter from the NAIC says: "This draft is not carved in stone. We are still anxious to make improvements and look forward to receiving your comments."

So much for the state scene. Let's turn for a moment to Senator Hart's bill. It's title was changed, as you know, from "Truth in Life Insurance" to "Consumer Insurance Information and Fairness Act." The bill contains several points. I think you have read about them, but I would like to just mention them quickly.

It empowers the Federal Trade Commission to establish minimum standards for disclosure and comparison, but it leaves to the states the implementation of those standards.

Secondly, it has a point-of-sale disclosure system essentially that of Professor Belth. It includes year by year data. The example in the bill quits at attained age 75, although if one reads the bill it covers year by year data all the way to maturity at age 100, if necessary. I am not sure if that was an oversight in the bill, or if the example violates its own bill. It also includes "company retention" information, which is Belth's approach. Though it is not in the example and there hasn't been much said about it, the disclosure piece would also include the company's 13-month LIMRA type policy lapse rate. This would all be delivered prior to signing the application.

A third requirement of the bill is that every time a premium is billed, and I assume they only mean annually, the company would inform the insured of the premium, the dividend information, and compare the dividend being paid with that which was illustrated years ago when the policy was issued. It would show the amount of protection (the net amount at risk) and the cost of insurance based upon that net amount of risk.

Fourthly, the bill contains the so-called "agent's bill of rights." Among other things, it guarantees an agent who has been under contract three or more years the right to sell products of companies other than his primary company. Such agents would also be fully vested at the end of three years. This three-year rule is obviously an accommodation to the financing and validation requirements related to a new agent.

The fifth area, one about which little has been said in the press, would require the FTC to periodically publish a guide. That guide would compare and rank insurance companies on the basis of dividends illustrated at the time of sale as compared to those actually paid.

I personally think there are several elements about this bill that are worrisome.

1. The buyer would be given a maze of numbers. I think he will only be confused and virtually never helped by the information on that disclosure sheet.

2. I have not seen or heard any demonstration that these pieces of data will meet and will help solve the problems which many of us agree do exist. It seems to me the burden of proof is on those who offer a solution to show how and why it will meet a need and will solve the problem.

3. Compliance will be very expensive and troublesome with that type of document.

4. The psychology engendered by comparing the dividends actually paid with those illustrated at issue scares me. The suggestion made by such comparison seems contrary to what a dividend is, actuarially and legally. I recognize that effort as an attempt to address the problem of controlling overly generous dividend illustrations which were perhaps arrived at capriciously. There may be some of that today, though, in my opinion, very little of it. For example, we didn't sense much, if any, of it in the questionnaire on dividend philosophies that our committee compiled and analyzed. There could be more of that in the future, however, if the buyer learns there are cost differences in life insurance and that he should shop for reasonable costs.

While I don't have a comfortable solution to that challenge of controlling overly generous illustrations, I certainly don't want to see the solution of the Hart bill.

5. The lapse rate on a company's policy is not useful information to the individual buyer. If regulators are concerned about a high early lapse rate, and I think they have good reason to be, there are better ways to address it than this.

6. There are some details in the so-called "agent's bill of rights" section which bother me. One small but usually overlooked one is the reporting to the state insurance commissioner of the circumstances surrounding the termination of each and every agent, no matter who initiated the termination. I guess I must leave to others more knowledgeable than I the evaluation of this entire section of the bill, but it is troublesome, and it is making people think about that situation. I think that is good.

7. The imposition of federal standards to be implemented by 50 states worries me for at least a couple of reasons. First, I'm worried about the lack of uniformity that is almost certain to result. Secondly, I am worried about the move toward federal regulation that this seems to represent. Personally, I feel something must be done to improve the efficacy of state regulation. It has got to be improved. I am not sure federal regulation is necessarily all bad, but I am sure this is no way to creep into it.

What is going to happen with the Hart bill? I doubt if anybody knows, but we do know that Senator Hart is not running for reelection. We do know that Dean Sharp, who did most of the work on this, has been gone from Senator Hart's staff since December of 1974. However, I don't believe we should assume that nothing will ever become of this bill. That would not be very prudent. But the most I can foresee in the near future is a set of hearings, perhaps next year, in which the industry will be called to debate the bill and to comment upon the facts that the Senate has gathered during the last three years. The U.S. Senate has gathered much information, and I think there is plenty there to make the industry uncomfortable. Certainly we should be concerned about such things as 40 to 50% first year policy lapses, the disparity in policy costs and the existing system which permits their perpetuation, and the high turnover rate of agents. The Senate staff has much data on these and other points. It is in the industry's best interests to act rather than simply to react to that information.

What can each of us do? In closing, I'd offer five very brief suggestions:

1. Review our own company's or client's practices and materials. It is surprising what you can find. I know I am reasonably comfortable with the way most of the material is now handled back in my office. But it wasn't always so. I know there are still items to be reviewed and improved. Ask questions, visit with your sales people, learn what your company is doing and see if you are comfortable with it. I'm personally ashamed of the slowness with which our profession has reacted to help in cleaning up some of the sales materials, or that we had to react rather than take the initiative in the first

place. Clear and non-misleading sales material is not necessarily bad or ineffective sales material. It can be very effective. And deceptive material, no matter how many sales it makes, is bad sales material and should be abandoned.

2. Plug into what's happening. Listen and watch state and federal developments. Regulators and legislators need and frequently want our help, help from the actuarial profession. Be credible in your contacts with them. Adversaries can be mutually credible. I have been very impressed with the integrity of many whom I've met in the last three years, though I haven't always agreed with them, nor they with me.

3. Urge uniformity in state regulations. That is increasingly important, and it worries me greatly.

4. Put yourself in the buyer's shoes. Try to see it from the buyer's viewpoint, and then try to make the market better for him.

5. My final comment relates to a quote from Joe Belth's book, Life Insurance: A Consumer's Handbook. Recall the sampling of survey findings with which I began these remarks, as they related to the buyer's ignorance in the marketplace. See if you agree or disagree with this quote from his book. If, like me, you tend to generally agree with it, then see what you think you should do about it. "Those who know the most about life insurance and who must therefore assume the primary responsibility for the ignorance in the life insurance market are the actuaries."

MR. ERNEST J. MOORHEAD: I wish to draw the attention of this group to two developments that were not mentioned in the excellent presentations on the subjects of disclosure and cost comparison. The first is the approaching hearing of Senator Stone on the information needed for veterans who are converting their government life insurance to individual policies in private life insurance companies. This hearing will be held on December 3 and 4 and is of importance for two reasons. First, this question was the start of the whole subject of cost comparison questions. It was in 1968 that Senator Hart started with the alleged lack of helpful information for veterans in connection with the conversion of their insurance. Secondly, if the government is going to make inroads into the private market, this is probably the easiest place for them to start. I shall be testifying, and I've received a substantial list of clearly worded questions to wrestle with.

The second development is the activity in Canada. The Canadian Institute of Actuaries has a committee on this subject and one question in their draft report, which I understand has not been approved by the Council of the Canadian Institute, is that of manipulation of policy values by actuaries. They have said that cost comparisons are not of any real value to the consumer if the policy rankings which they produce are susceptible to manipulation by minor adjustments in policy values. Maybe so, but I have not seen evidence to support such susceptibility to manipulation in a snap-shot type of index such as the interest-adjusted. I think that some documentation of that statement is sorely needed. This manipulation issue has not been sufficiently grasped by actuaries. We have tended to back away from the subject.

I was the author of the research report to the NAIC cost comparisons committee on the subject of manipulation. I was very careful not to indicate in that report that I thought or knew about manipulation existing. In fact, I do not know of manipulation of the kind that was involved in the definition. I certainly agree with what has been said about the importance of professional rectitude on the part of actuaries. I don't believe that a convincing case has been made that actuaries have manipulated policies in a manner that would make them competition proof against a system that does take the time of payment into account. I will certainly admit that if a system does not take the time of payment into account then almost anything goes. But the traditional method has been so thoroughly discredited that I doubt very much it will come to life anywhere except in Probe.

Finally, I would like to ask the question "Has the actuarial profession given its best help to this issue through the years?" As Mr. Munson indicated, his committee has been disbanded. This is perhaps the most appropriate moment to ask ourselves, as actuaries, whether we have done the job as a profession that we should have done. I would like to give full credit to the Munsom committee for having dealt with the matter within the charge given to it by the Board of Governors. Nothing that I say is critical of the work of that committee, even though I have taken jabs at the committee on particular issues in their reports. Look at the Society of Actuaries and the history of its public expression of professional opinion, from the argument in Chicago in 1967 as to whether the profession should be free or not, to the development in 1970 and 1974 of a positive statement in the constitution that such public expression is appropriate and desirable. Then look at this, which is one of the first tests (along with the audit guide). Have we done as creditable a job as we could have done? I doubt it, ladies and gentlemen.

I think we could have expressed ourselves more clearly as a profession than we have. But allowances should be made because we are young at this. There will be other issues, and I hope that the experience that we have had will cause us to be even more forthright than we have been in this particular matter.

MR. MUNSON: Our committee took some satisfaction in the frustration among some members of the profession that we were not opinionated enough in our reports. As Mr. Moorhead acknowledges, our charge did not encompass opinions, but was to do research for the NAIC. Our committee went just about far enough under those circumstances, at that time, and on that subject. I hope that the profession will have opportunities to go further and do so soon.

The dividend philosophy matter is of growing concern to a great number of actuaries, myself included. We did issue one report on that subject, but again that was just a compilation of the practices according to a questionnaire and again was within our charge. There's a need for a group to address the subject that Bill Sutton discussed, and I hope that will happen soon. There, I think we can be or should be more opinionated.

MR. ROBIN LECKIE: I'll speak on behalf of the Canadian Institute of Actuaries. In response to Jack Moorhead's inquiry, we have had a committee on cost comparisons similar to the Munson Committee. A report has been prepared and was introduced to our membership at a June meeting this year. This report has been received by the Council, but not yet endorsed. It has been sent back to the committee for completion of the committee's recommendation of a further investigation of some comparisons, based on the company retention method, which is recommended in the report.

Now, I would like to clarify how a federal agency can propose the company retention method when the state agencies are proposing the interest-adjusted method. We who have discussed this report do not feel that actuaries can endorse the interest-adjusted method as the most actuarially sound one. The report feels that the company retention method, being a group average method, is the most reasonable actuarial cost comparison basis the NAIC is going to ask for. We are not saying it is necessarily the most reasonable method for a comparison at the point of sale. It is quite possible that we would make a public pronouncement to the industry and to the regulators that the company retention method is the most actuarially sound basis. If it is considered at that level, then the interest-adjusted method, which is an event specific method, could be used at point of sale. This would halt the criticism of manipulation that can be addressed to an event specific method. I don't know how seriously the interest-adjusted method can be manipulated, but it can be. As long as it can be, it is going to be subject to criticism. We hope that at the industry and regulatory level we might halt any possible manipulation.

MR. THOMAS F. EASON: The panel today has rendered an outstanding educational service and my compliments to all of you. Bart, your ability and forthrightness today is just outstanding. I wish at times that you could find a way to work full time and lead members of the profession in some of your views and application of your actuarial abilities.

The report of the Society's special Committee on Non-forfeiture Values includes a finding that a six-year age setback for women is a reasonable reflection of the sex differentials in life insurance mortality today. The reported rumors on the three-year age setback being inappropriate have been confirmed, at least in the report of this committee. Although the committee did not have a specific charge of developing a new ordinary mortality table or tables, it is hoped that the numbers and brief analysis presented will add new facts to the current discussions.

In a new product workshop yesterday, there was an intense discussion on deferred individual annuity dividends. The new money philosophy has strong proponents, and strong opponents of which I was one, because of (1) the probability of dividend reductions on this type of business, (2) the unqualified accumulation illustrations of competing non-insurance financial institutions, and (3) the marketing interests in individual retirement accounts and annuities. Mr. Sutton, what is your view of the new money dividend philosophy?

MR. SUTTON: With respect to any kind of ordinary policy, where premiums are level and payable over a long period of time, I don't see that a new money philosophy is applicable. If you get into that situation you ultimately, after maybe 15 or 20 years, reach a point where the cumulative rate on that kind of business is the same as the current portfolio rate. If at that point the new money rate gets below the portfolio rate, which I think we're going to see sometime in the near future, we are going to have an awful time trying to figure out how to apply that lower new money rate to new products issued at that time without being very noncompetitive.

MR. WALTER N. MILLER: I would like to share with you something that we at New York Life are developing. We think it will be helpful in the area of service. We are trying to work out the final details of a warranty which will provide that during the first five years of the policy, or before it travels 50,000 miles, any policy provisions which turn out to be defective will be replaced free of charge. My tongue is only half in my cheek, because I think that one of the most important ways that we really can give the kind of service that we

should is in constantly striving to improve our products and come out with better, more liberal, and more flexible policy benefits and provisions. I don't believe that all of us are conscious enough of the fact that when you do something to improve or liberalize a bright new policy, we owe it to our existing policyowners to make the same sorts of improvements and liberalizations in old policies.

I certainly agree that service is important from the standpoint of basic corporate responsibility, but, Mr. Eichhoff, I was surprised that you did not mention the agent in your presentation. Doesn't the agent have a vital role to play in this whole service question? Perhaps you can't just say "We will give an agent a 2% service fee and that will take care of everything, won't it?"

MR. EICHHOFF: As I indicated earlier in my remarks, this was one of the first questions that the committee addressed itself to. We had a subcommittee reporting to the LOMA board on this subject before we formed the LOMA/LIMRA joint committee. As long as this was within LOMA, the contention was that essentially the service responsibility belonged to the home office. As soon as we involved people from LIMRA, they wondered why the home office should get involved in this at all, because service is really the responsibility of the agent. I would like to think that is one minor contribution that I made because of my own personal convictions and background. I am convinced that you cannot designate one person as the only person responsible for good service.

Some companies philosophically say that the agent is the service mechanism that the policyholder or client must look to for all service needs. If a company decides that, that's their prerogative. But we were trying to say that, first and foremost, it is the corporate responsibility to assume all responsibility for service. The company, in turn, can choose how they want to delegate that responsibility.

There is lots of life insurance sold without agents. Who should service these policies in the absence of an agent? We also have millions of policyholders in many companies that are not assigned to an agent. These are examples of why an agent can't be the only conduit through which service is provided. Each company must determine how they are going to do this.

MR. MILLER: I wasn't trying to suggest that the responsibility for service be solely placed on the agents. I was trying to suggest that where there is an agency force it is hard for me to conceive of a situation where a company can be satisfied that it is doing a good service job without getting the agent involved.

MR. EICHHOFF: Each company must determine if they have the right then to assign a policy to an agent for service without any compensation or remuneration when a policyholder requests service and there is not an agent-client relationship. That is a question each company can decide for itself. An increasing number of companies are not providing long-term service commissions or service fees for in-force policies. So, do you ask an agent to make a service call where there is no compensation involved except for the possibility of developing a new prospect for additional sales? Some agents don't care to offer that service, because the policyholder is not a client. Increasingly, agents are dividing their customers into two groups, clients and policyholders. Clients are the ones they really serve, policyholders they put up with.

MR. CALVIN SPEDDEN: Mr. J. Alan Lauer prepared some remarks on the subject of illustrative versus payable dividends which he asked me to present.

MR. J. ALAN LAUER: Many actuaries seem to believe that, barring legal restrictions, an attempt should be made to illustrate dividends that might actually be payable on the policy for which the illustration is being made. The older, traditional view is that dividend illustrations are merely a representation of the dividends actually being paid in the current year on policies already in force. While a brief review of history is not likely to resolve this controversy, it might be helpful.

Most participating life insurance is issued by the mutual companies. Many of the mutual companies experienced a long period during the first half of this century in which their scales of cash values did not change. Likewise, many of these companies did not change their scales of gross premiums during this period. Under such conditions, when a company said that the dividends illustrated were those on its current dividend scale, it meant literally that those were the dividends currently being paid. For example, one company supplied its agents with a dividend booklet which contained the following statement: "The dividends shown in this booklet are the dividends that will be paid in cash during the calendar year 1923. The dividends are given for the first ten policy years and will be payable on policies completing the corresponding policy year in 1923."

It appears that in the early years of this century, companies were quite conservative in the number of dividends illustrated. The figures were generally developed by hand, and modern duplicating machines had not yet been invented. Some companies illustrated as few as 5 dividends, but gradually progressed to the illustration of 10 dividends, and then to 20 dividends. In the 1930's, at least partly because of the advent of Social Security, an interest arose in policy values at retirement ages, and the retirement benefits that they would provide. At the same time, the great decline in dividends in the 1930's (a dramatic and negative testimony that dividends do reflect experience) led to a reluctance to supply illustrations covering many policy years.

Since then, an increased emphasis on retirement benefits, the availability of electronic computers and duplicating machines, and the need to present adequate illustrations of "fifth dividend options" and other benefits have brought us to a situation where the number of dividends illustrated seems to be unlimited. Somewhat illogically, this increase in the number of dividends illustrated at the time a policy is issued has been accompanied by an increased faith on the part of both agents and policyowners that future history will actually conform to the numbers being illustrated. One factor contributing to this situation is the ascendancy of the computer, which seems to be widely accepted as infallible. Another factor is that dividend scales over the past 20 years have, with few exceptions, steadily improved, with the result that many of our agents (and, judging from actuarial examination papers, some of our actuaries) believe that dividend scales can only change in one direction, so that the actual facts will never be worse than those being illustrated. It would seem that the mutual companies, and those stock companies issuing participating business, should try to do a better job of educating the public, and themselves, about the nature of mutual life insurance and of life insurance dividends.

The situation is now being even more confused by well-meaning consumer advocates who have little understanding of the complex nature of the life insurance product, and who seem to think that actuaries are nearly as infallible as computers. Some of these individuals appear to believe that dividend histories should be compared with dividend illustrations to see which companies do not live up to their illustrations. They have succeeded in changing Schedule M of the NAIC Annual Statement from a device by which a limited check could be made on whether a company is treating different generations of policyowners fairly to an accumulation of numbers of little or no value to anyone. These people apparently think of the dividend as a fixed benefit, similar to a pure endowment. In such a case, the policy would actually be nonparticipating. A company which exactly meets its dividend illustrations over a 10 or 20 year period may appear to some of these uninformed people to be doing a commendable job, but, in my opinion, such a company is actually misleading the public by labeling its product as participating insurance. Life insurance is not participating unless the dividends reflect the experience of the company, and I find it nearly impossible to conceive of a company whose experience would not vary over a 10 or 20 year period.

MR. PAUL D. YEARY: The idea that companies are not allowed to have an exclusive agency force, which showed up in the Hart legislation, is something we really need to be concerned about. It doesn't seem to fit what they're trying to accomplish. I will admit that maybe over the years it has contributed to some problems, but I really feel that this is going to have a tremendous impact and it hasn't seemed to generate much discussion.

MR. MUNSON: I have some thoughts about the freedom of the agent. I think it's striking a little bit at our wanting it both ways in the industry. We hold out the agent as the totally independent professional counsellor who has only the buyer's best interest at heart. But, at the same time, we pay the agent only if he sells our contract. Not only that, but we pay him differently, depending on which one he sells. And I'm troubled by the industry wanting it both ways. I am also troubled by the solution of the Hart bill. That's why I copped out by saying I leave it to others who know more about that subject than I do.

MR. MOORHEAD: There are two phases to this question. One is granting the agent the right to sell business in a company other than his own. The other is the question of vesting renewal commissions. It should be stressed that what Senator Hart is really doing is trying to stir things up. I haven't any particular reason to think that he is, heart and soul, behind every one of the proposals in the bill that we are now discussing. As he said in his introductory remarks for public discussion, he feels that there are some problems, and that the way to get enough discussion of those problems in order to reach a better solution is to put something on the table.

On the question of writing business in another company, I have been saying that what Senator Hart is really asking for already exists and is just a matter of the companies recognizing a situation that they tend not to recognize. I worked for 15 years for a life insurance company that had a provision in its agent's contract that permitted the agent to write business in another company. I can see no difference between the results achieved by this company and the results achieved by companies that didn't have such a provision in their contract. As far as I know, almost all companies are permitting it with only occasional, special case exceptions. I think the emphasis really is not so much on permission to write business in another company, but on the reason for the agent writing business in another company. I have received some letters recently suggesting that it is absurd to think that the agent would take the

best interests of the buyer into consideration. I do not share that opinion. I think the agent can be, and in most cases is, just as ethical as an actuary. He is capable of taking that responsibility.

I am a strong believer in the value and appropriateness of non-vested renewal commissions. I would like to see the life insurance business come out with a candid and straightforward statement, giving the pros and cons. I believe that such a statement would clear the air from any conclusion that non-vested renewal commissions indicate captivity of the agency force and are undesirable from the standpoint of the life insurance buyer. When this matter first came to public attention, Senator Hart received a large number of letters from disgruntled agents. Many of those letters did not state the case objectively.

MR. SUTTON: My company is one that is very much committed to a career agency force. We do very little brokerage business. When the Hart committee report first came out suggesting that agents be freed after three years, the reaction of the head of our marketing operations was "maybe that's not too bad." The agents producing the largest amount of our insurance do a substantial business in other companies. If this comes to pass, maybe we won't have to subsidize them as much as we do for selling the rest of that business.