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FUTURE OF NON-CANCELLABLE DISABILITY INCOME

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1. Have recent social security and economic developments outmoded traditional Non-Can Disability Income products?

   What changes in provisions and benefit design are needed to allow for these recent developments?

   Can Non-Can Benefits be co-ordinated with Social Security to provide adequate but not excessive supplementation at all times?

2. Can Non-Can Disability Income be maintained as a sound coverage in the future, as to cost and contract provisions?

   What is the profitability of current Non-Can portfolios? Can vanishing profitability be restored?

   What long-term trends in incidence and duration of disability claims are indicated by recent experience?

MR. E. PAUL BARNHART: It is no secret that the disability income insurance business has fallen on hard times over the last 3 or 4 years. The evidence is everywhere:

Item: Some carriers that consistently showed underwriting gains for 30 consecutive years suffered underwriting losses in 1974 and 1975.

Item: For some carriers the average duration of disability claims has increased by as much as 25 to 30% over the last 4 years.

Item: Some carriers have increased their minimum earned income rules for issue or participation by 150% or more, within the last 5 years; in some cases resulting in the disappearance of as much as 50 to 75% of what they once considered their "market".

So what is going on? Everyone, of course, can point to the recent recession and the associated economic instability and high unemployment. Hopefully, however, these conditions are at least relatively temporary. Of greater long-term concern and significance to private disability income writers is the breakneck rate at which disability benefits have been escalating under the U.S. Social Security System.

Consider just the last two years. In 1974, a worker disabled at age 55 was entitled to a Maximum Family Benefit of $557 monthly. In 1975, this increased to $618, up 11%. In 1976, it increased to $654, up another 6%. The average annual rate of increase over the 2 year period was 8%.

But if an 8% annual rate leaves you a bit shook up, consider a worker disabled at age 25. His MFB in 1974 was $718. In 1975, it was $848, up a staggering 18% in one year. And in 1976, it was $957, up another 13%, for an average annual rate over the 2 year interval of 15%. No wonder the industry suddenly found itself drowning in overinsurance!

MR. H. CAREY HANLIN: In considering the future of the non-can disability income business, it might be helpful to first take a look at where we are and how we got there. Let's review some of the things that have happened to the disability business in the last ten years.

During this period, many of us have yielded to competitive pressure and have liberalized substantially the definition of disability. Ten years ago at Provident we had only one plan that paid as much as a five year benefit for disability based on a "his occupation" definition. Today we sell benefit to a select class risk with a his-occupation definition all the way to age 65. For any white collar risk we will provide a "his occupation" definition for ten years.

Ten years ago, the maximum sickness benefits which were available were for five and ten years duration and accident benefits were payable to age 65 or for lifetime. Today a large volume of business is sold providing benefits for both accident and sickness to age 65 or longer.

In the last ten years the maximum limits of issue have been increased substantially. Ten years ago the maximum non-can benefit that most companies would issue was approximately $1,000 per month. Today this has been increased to $3,500 per month, and some companies go even beyond that. The limits of issue may have been too low ten years ago for the higher paid professional; perhaps the increase is not as significant as it appears. Nevertheless, when the current limits are coupled with increases in Business Overhead Expense insurance and the introduction of Buy-Sell products, the amount payable on a single life becomes quite large.

There have been other and perhaps less significant liberalizations. Until recently there were restrictions on what companies would write for women, but state regulations have effectively removed these restrictions. Formerly we provided presumptive disability benefits only for the benefit period of the policy and only as a result of accidental severance, whereas today most companies provide lifetime presumptive disability benefits for loss of use as a result of either accident or sickness. Ten years ago we did not have a retroactive waiver benefit, which most companies do provide today. And during this period, with all these liberalizations, companies have reduced premium rates and increased commissions.

Many of the changes have been quite realistic. However, in some instances the industry may have done more than might be desirable. Segments of the industry feel that the liberalization in the "his occ" definition of disability to provide benefits to age 65 is one example of this. Other company representatives feel that the limits of issue have gone far enough for today's economy or even too far.

In spite of these changes and with certain reservations, we nevertheless feel that, for us, there is a future in the conventional disability income market.

In considering our position, however, it is necessary to recognize that Provident only operates in a restricted segment of the disability income marketplace.

Provident's individual accident and sickness department operates through a limited number of brokerage offices located in the major cities of the United States with subsidiary district offices in smaller cities. Even general agents of Provident's life department submit their disability income business through these branch offices.

These branch managers derive a significant portion of their business from agents of companies that are not in the non-can business and companies that do not write a long-term non-cancellable disability policy. The majority of the business is written by producers who are members of the Million Dollar Round Table, people who are writing large amounts of insurance to applicants who are in a higher income category.

The majority of the disability income insurance written by Provident is on professional and executive people and others in the top two classifications. Only 4%-5% of our total sales, both currently and in the past, have been to blue collar risks.

In this higher income market we do not see new provisions and benefit design as necessary except to the extent that companies must always be responsive to changing economic conditions.

In that connection, about two years ago we at Provident, following the lead of some of our competitors, introduced a Residual disability benefit. The limited experience we have today does not indicate any particular problems in either underwriting the risk or in claims. We had quite a bit of background in writing a short term residual benefit since we were one of the early carriers to offer partial benefits for sickness as well as accident. Our experience in partial had always been satisfactory and, while the residual is a long-term benefit, we feel the requirement of a material earnings loss combined with a meaningful qualification period of total disability offers protection against adverse selection in this arena. Perhaps this benefit will shift the emphasis from pure indemnity to the replacement of a loss in earnings.

Although we believe there is a place for the traditional non-can product in the higher income market, we do feel that changes are necessary in the lower-income market.

As stated earlier, we write only a minimum amount of business in the blue collar market, and our experience has not been satisfactory. For that matter, in the last couple of years a number of companies have sustained underwriting losses in writing non-cancellable disability business. Our discussions with other people has led us to believe that this adverse experience could, in the majority of instances, be largely traceable to business written in the blue collar market on people with relatively low incomes. Frequently the adverse experience appeared to result from having written disability policies providing benefits on the basis of either first day, eighth day, or sixteenth day coverage. These are the people who are most affected by economic recessions, with resulting unemployment, and this is the area where over-insurance from Social Security disability benefits has its greatest impact. In this market, there is reason to believe that the experience might continue to be unfavorable.

In fact, in the lower-income market, we question whether there is any significant long term insurable loss. Social Security benefits have become quite substantial and, in many instances, the moderate income wage earner with several children find that Social Security disability benefits virtually replace his whole income. For people who earn less than $14,400 per year, we will therefore no longer issue a traditional non-can policy except for those applicants who can anticipate a fairly rapid and continuing increase in earnings.

Our sales to the lower-income risks are, to a great extent, to the female employees of professional people where the insurance is written to provide a salary continuation program for all of those associated with a given business.

In this low income market we will not write a non-can policy on the blue collar risks, but only a guaranteed renewable policy. We will write only one non-can policy on lower income white collar risks. This is a package policy which provides benefits approximately equal to 65%-70% of salary in the first benefit year, reducing thereafter to a benefit of approximately 25% of salary, depending upon income at the time the policy was issued. Since the benefit is not adjusted after issue to reflect increases in income of the applicant, it is at best an effort to offset to some degree the problem of over-insurance.

Five years ago we experienced morbidity that was almost too good. Since then, claims have increased. It is not clear from our studies whether this is definitely an increasing trend, or whether some of the increase results from the increasing attained age and the maturing of the business.

Following are some observations based on our recent morbidity experience:

(1) The claim costs for accident-related disabilities have shown a significant increase during the period 1972 through 1975. This increase in claim costs is primarily related to an increase in duration of claims and not frequency. The increasing pattern is observed in all classes of risk, particularly among white collar insureds, and is associated with elimination periods of 30 days or less.

(2) Our aggregate sickness claim costs have remained at relatively the same level during the past three to four year period. There is come indication of an increasing trend in the 50 and over issue age group but not to the same degree as observed for the accident claim costs. Any trend of increasing morbidity based on sickness-related disabilities has taken place in the lower income and lower occupational blocks of business. Over-all, neither the duration nor the frequency of sickness-related disabilities has shown any significant changes during the past three to four years.

(3) Since our accident claim liability represents a lesser proportion of our total claim liability than sickness, our aggregate claim costs have increased at a considerably lesser rate than accident claim costs during the recent three to four year experience period. This increase in the aggregate has been approximately 10% over the period 1972-1975. Obviously, part of this increase will be due to the increase in the proportion of business maturing into the ultimate morbidity range.

Although there is some concern on our part about the increase in accident claim costs during the recent past, the aggregate level of accident morbidity is not exceeding the morbidity margins incorporated into our gross premiums. The aggregate morbidity level of accident and sickness combined is well within the range of the morbidity margins built into our premiums for white collar business.

(4) We have made calculations each year for the last four years on the ratio of actual incurred claims to expected claims. Expected claims were calculated using a recursion reserve formula with certain approximations which in our opinion do not affect significantly the validity of the results. In the aggregate, this ratio of actual to expected morbidity has been level for the last four years and is still less than what was assumed in our current rates.

One apparent source of some of our adverse experience seems to be the selection against the company by a claimant who owns a policy providing short term sickness benefits but long term accident benefits. We find that some dormant sickness problems are surfacing due to an apparent accident. Perhaps we ought to sell only co-terminus benefits.

Another factor is a result of the current malpractice problem. We find that doctors are very hesitant to tell a patient that he has improved as much as he can anticipate and that the patient might as well go back to work. Doctors now tend to let the patient decide that. If we are seeing an adverse claim trend, we do not yet know whether it is a result of more liberal provisions or whether it is a result of external forces which are at least partially beyond our control.

Then there is the question of profitability. Ten years ago the non-can disability business was extremely profitable. During the intervening period we have significantly liberalized benefits, reduced premiums and increased commissions. When these are combined with the impact of inflation upon expenses, it should be no surprise that profits are decreasing. That profitability can be at least partially restored when we all realize that we cannot continue the spiral of ever increasing liberality. In addition to that we must still react to the external forces which our business faces.

Disability income writers face a number of such challenges, and our future as an industry rests on our ability to meet these challenges. Some of the factors that will affect the soundness and profitability in the future include the following:

(1) First is the continuing expansion of the Social Security system. This will undoubtedly continue to erode our market.

(2) A major concern is the matter of over-insurance. In addition to the effect of increased Social Security, State Disability, and Workmen's Compensation benefits, over-insurance has intensified in recent years in the professional market as a result of the large benefits written through association disability plans without regard to other insurance in force.

(3) Then there are the problems of the economy. On the one hand there is the possibility of repeated economic recessions and their effect on unemployment. On the other hand, we are all concerned with the impact of inflation on our business.

(4) It is still too early to be able to detect any claim trends from the introduction of the "his occupation" definition of disability to age 65 and the residual benefit. Obviously the effect on claims of these benefits must be carefully monitored.

(5) A concern with the increased use of the "his occupation" definition of disability is related to the advances in medical science. With improvements in medical care, many people who would formerly have died are now surviving serious disabilities and, although unable to perform the duties of their original occupation, are now able to function in some other position.

(6) Finally, the changing legal attitude offers a very real challenge to the successful operation of companies in the future. This includes the liberalized attitude of courts in granting judgments to claimants, the significant impact of punitive damage awards, and the ever increasing problem of new regulations based on social principles instead of what we consider to be sound insurance and actuarial principles.

We cannot afford to act complacent and assume that we can maintain the status quo in this marketplace. Our ability to react to the challenges enumerated here, as well as others that will arise in the future, is the key to our industry's success, and in reacting to these challenges, we must all be concerned about the future integrity of the business.

We believe that responsible action by the companies engaged in this business can lead to a future which offers the opportunity to operate profitably, although perhaps with lower profit margins and certainly in a somewhat more restricted market, and we therefore view the future with cautious optimism.

MR. W. DUANE KIDWELL: Where did all the profits go? For a stable line of business, such as life insurance, where there is very little change in the risk trends from year to year, an occasional look at history with a projection of the slow moving mortality trends is sufficient to keep us on an even keel. The Disability Income line, however, has highly volatile claims rates and history is less important than is the judgment of future trends. The magnitude of risk changes gradually with changes in the insuring clause or violently with changes in economic conditions. It increases with increasing adequacy of coverage and with loosening standards of mores and work ethics. In so volatile a line as disability income the importance of constant, careful monitoring of the morbidity, and other premium parameters as well as sales, underwriting and claims practices cannot be overemphasized, and we have been monitoring. Monitoring without effective action, though, is wasted effort, and we have been wasteful. Comments made in the TSA's in 1966 show that as technicians we were very smart in our judgment, but history shows we have been ineffective in controlling the types of products and greed for sales volume over soundness. Our companies offer what actuaries consider generous products in unsound amounts and we should not be surprised that, when the opportunity presents itself, the public takes every advantage of our generosity.

The U.S. has been going through a recession. Profits faded during the recession. Was this the cause or was it a coincidence? Our own company's statistics covering this period, as you would have expected, showed a steady deterioration in the blue collar rate of recovery from disability although the rate of disablement rose very little. This deterioration was undoubtedly accelerated by the claims anti-selection that results from over-insurance and from relaxing personal ethics that manifest themselves in periods of high unemployment.

Group insurance, OASDI benefits, workmen's compensation and state cash sickness benefits are all designed to provide a floor of protection to avoid the disabled person's becoming a burden to society and to provide peace of mind to him and to his family in an area where he might not otherwise provide for himself. These basic insurances are now so adequate as to make it unsound to offer additional coverage to any person earning less than $15,000 annually. To illustrate, a U.S. family with 1 child earning $15,000 has a net income after Social Security and income tax of $960 per month. After deducting his extra working expenses of 10% and allowing for an element of coinsurance of 10%, the net insurable income is about $770 per month. The benefit from OASDI alone is over $800 per month after a 5 month elimination period.

Over-insurance on disability income occurs whenever the family's net spendable income is exceeded by the potential tax free disability income plus whatever value the insured gives to added leisure time. When this occurs, the financial motivation to return to work is gone and it is more attractive for the insured to remain disabled. If there is no job to hurry back to and if social principles do not prevent accepting money that is not earned, the recovery rate suffers.

Ten years ago in a period of high economy profits from this line of business were very attractive. Several companies entered the field, not only for the profit potential, but to broaden their agents' field of operation. With so much in prospect, aggressive competition developed, primarily in the professional market. Policies were sold providing longer and longer periods of coverage under an ever liberalizing of the insuring clause. The popular benefit period grew from 2 years, to 5 years, to 10 years and on to age 65. The "his own occupation" definition of disability (providing benefits while the insured is unable to perform the duties of his specified occupation) was extended to 2 years, 3 years, 5 years, and on to age 65 (or even life in some instances). "Specialty letters" are being issued with the policy to more narrowly define the occupation as a particular specialty (i.e. dental surgeon, trial lawyer, retinologist) such that there is now the possibility of collecting permanent disability benefits from very minor physical or psychological causes often while still earning significant income in other occupations. Currently the residual earnings clause is reacting to the same competitive pressure for a more generous definition to the point where the industry could be accused of promoting an indefensible, attractive nuisance. I am concerned that companies are providing this too liberal insurance clause in excessive amounts solely for the purpose of sales motivation.

Because of this, over-insurance is becoming increasingly more dangerous at the higher amounts where tax free incomes of up to $4,000 per month to age 65 encourage the extension of a disability to a degree accommodating your insuring clause.

A person does not want to be disabled, of course, but if he is disabled it is comforting for him to know that he will be at least as well off financially while disabled as he is today. If he is highly specialized and if his skill is impaired he may have little confidence in his ability to readjust to a different occupation. This sounds logical - so where is the problem? Most claims are bonafide, of course, but the generous benefits tend to prolong them. There are too many claims where disability cannot be disproved though the allegations are highly suspect. (For example, a urologist on claim who is happily teaching school while collecting full benefits because he developed a hesitancy to make decisions in his practice.) I have heard of a couple of instances where claims have been incurred on a perfectly legitimate basis but under which the benefits were so generous that the insured actually increased his income by not going back to his regular occupation. In these instances it was easy for the claimants to adjust to other occupations where they will probably remain until benefits run out.

Some of the deterioration experienced is from abuse, of course. The stakes are high and so attractive as to encourage it. The far more significant factor is that we have sponsored a change in social standards and work ethics that leads to a different level of claims rate. It is a universal hazard that cannot be underwritten out and therefore it must be priced. High claims prospects (frequently over $250,000) attract punitive damage action against claims handling and inherently would affect the reviewer's decisions on questionable claims. The threat of malpractice suits undoubtedly affects the actions of our medical consultants, who, out of fear, may hesitate to declare a claimant fit for work. This could be adding days or months to each claim, and I suspect that it is a big factor in the slowing down of recovery rates. This is not necessarily bad, if abuse can be avoided. We all want the better standard of living where we do not have to return to work until all of our aches and pains are gone, but we must pay the price in higher premiums to cover the added use. As administrators, we are becoming gun-shy in curbing such stretching out of illnesses, and in defending the intent of the contract.

Another concern of the health insurance industry is the growing expense rate. Companies are fighting desperately to try to hold unit costs down by increasing the minimum size policy sold. We have been successful in the professional market but less successful in the blue collar area where the additional expense margins, because of restricted growth in average size, have not kept pace with inflation. Some state insurance departments and Canada, in particular, in the interests of protecting a fair value for the consumer, are beginning to force expense control by requiring companies to maintain specified minimum loss ratios. I believe this is necessary not only to protect a fair return to the consumer but to protect the companies from cannibalizing themselves with high commissions and other expenses.

One unfortunate part of the legal requirement is the increasing amount of reporting required which further increases expenses. Our hope is that the cost of expense control will be less than the cost of expense out of control. Based upon our current commissions, premium taxes and other expenses we find that we cannot profitably write policies under $350 per month and meet minimum loss ratio requirements.

There are certain markets in which it has been felt that so few policies could be sold and the size of benefit would be so small that to offer them would be impractical. This occurred particularly in the female disability income market. To be socially and legally acceptable today we must offer the same benefits to both males and females and are required by some states to offer some form of minimal benefit to nearly all persons regardless of handicap. This is an expensive requirement that forces the insurance companies to accept a social responsibility, while forcing the insured society to pay the cost.

Some developments, such as more adequate insurance, have helped to improve living standards and some, like over-insurance and job insurance, have encouraged the deterioration in mores. We will not here editorialize on the social advantages or disadvantages of these changes, but, rather, we will admit their existence and plan to operate accordingly, each company in its own way. May I share with you some personal thoughts on the future of disability income insurance:

Rates of recovery seem to have stabilized in the blue collar area and with prospects of continued 6 to 7% unemployment, they will remain on this new higher claims cost plateau. This does not forecast a very rosy future for many blocks of existing blue collar business now over-insured because of the rising floor of social benefits. Hopefully, higher than expected interest rates will offset some of the extra claims costs and there will still be expense recovery and some small profit.

The professional class of business is now beginning to show some of the deteriorating trends in recovery rates that we have been expecting and we must be deeply concerned with the prospects. I expect deterioration to become more evident in the professional class as a new standard of ethics is being stabilized. Our underwriters and claims departments have a big challenge to handle these changes soundly while at the same time keeping in mind that our basic purpose is to provide adequate benefits for true disasters.

We must solicit the assistance of the bar associations, the medical professions and the legislators to restore sanity in the punitive damage and malpractice areas. Counter suits could be encouraged, and punitive damage rights could be more clearly defined and legislated. Malpractice responsibilities must be more carefully legislated to protect the doctor's obligation to give an unbiased professional opinion. Legal fees should be limited by law as, too, should the financial measure of pain and suffering.

Benefit periods and amounts of indemnity that do not coincide for accident disability vs. sickness disability are simply not sound because the courts in particular and the public in general, sometimes refuse to recognize the distinction between the two causes of disability.

Elimination periods of 15 days or less exhibit terrible experience. Many companies have wisely raised the minimum elimination period to 30 days and others will follow. This seems appropriate because of the adequacy of sick leave benefits and savings accounts. Furthermore the high cost of administering shorter elimination periods is impractical and there is seldom a sound justification of a need.

The introduction of the CDT table as a valuation standard resulted in the establishment of much higher active life reserves than resulted on the conference table. This leads us to consider that, since we believe the CDT is closer to the truth, though excessive, there is a deficiency to be made up by some of our older business. This could well be a part of the profit and dividend disappearance. Combined with the reserve strain on growing volumes of the relatively lower premium professional market, a double blow against statutory profits results.

Multiples of the Commissioner's Disability Table (CDT) disabled life annuity factors are used by most companies for their claim reserves. At the time this table was first introduced, in the late 1960's, factors as low as 70% seemed to be adequate for first year disabilities although factors of around 100% were required for claims of longer duration. Since that time there has been substantial elongation of the earlier claims durations and substantial run off losses have occurred. As a result the factors have gradually climbed from 70% to 105% of the CDT factors for each of the first 3 years in our own company and to as high as 125% for first year claims in companies that have a higher proportion of blue collar policyholders.

The interest rates on claim reserves are usually 3 or 3½% even though higher rates were used for premiums. This is overly conservative on longer benefits and tends to defer profits by over assuming claim liabilities. Thus while we still may have a run off loss the forecast is brighter for the future. As larger numbers of claims of over 2 years duration appear these reserves will become so conservative that we will be asking for more realistic interest rates in minimum valuation laws. This would then be more consistent with GAAP accounting.

In addition to the currently popular "his own occupation" policy, many companies offer a residual benefits policy that continues proportional benefits during a period of rehabilitation. Some of these policies provide partial benefits while rehabilitating in "his own" occupation but full benefits if the insured does not re-enter his own occupation. These definitions emphasize job insurance in varying degrees in contrast to insuring lost income. Although the job policies are easier to sell, because they are more emotionally appealing, the residual benefit paying partial for rehabilitation in any occupation is more consistent with the intent to cover an insurable interest. I believe that policies will move towards a true replacement of lost income concept as companies begin to realize the severe delayed consequences of job insuring clauses.

Earlier we mentioned the expense problem. Not only have expenses been rising but to add insult to injury, early lapse rates rose during the recession, as well. We are experiencing an improving trend in these early lapse rates as the economy recovers. Low lapse rates aide in expense recovery, but may be more costly in later years where you lose the advantage of any released positive asset shares that may have been inherently assumed in your rate making formulae. Nevertheless lapses are high and replacement is too evident. Unless the industry will step forward and curb the replacement problem the insurance departments will do so. The consumer seldom gains by such replacements for he must repeat his issue expenses through a higher age premium. The company seldom gains because a move in will more often than not move on again and high new business expenses will not be recovered. In the long run it is only the salesman who really gains.

We will accept the fact that there will be continued higher unemployment and continued deterioration in mores and will price accordingly, with less emphasis on insuring the price itself. There will be more emphasis on experience ratings.

There will be more and better breakthroughs on the treatment of terminal illness that will sustain the disabled life for months, or even years. This implies longer periods of benefit and so greater costs.

In order to overcome the effects of rapidly changing economic conditions and insurance needs we will develop a shorter cycle policy. As actuaries we realize, of course, that the steeper the benefit curve the greater the proportion of net premium going into reserve for future benefits and so the more deferred is the profit. Thus it would be more palatable to have a short renewable term policy so that premiums are not required to support such a heavy reserve strain. Furthermore such a policy would give us the opportunity to experiment with responses to changing consumer demands, with more frequent opportunity to evaluate the results.

Hopefully, we will generate a premium structure for our renewable policy that can be filed with a predetermined schedule of premiums or amounts of indemnity that vary by defined experience loss ratios, thus eliminating the need for refiling rate changes. Perhaps we could add a flexible deposit account as a premium stabilizer.

In the future, there will be considerably more attention paid to handling health claims on a personal basis. Telephone communication will be used extensively, not only to stay in touch with, but to keep the claimant constantly reminded that we are interested in serving his best interests through his rehabilitation and his return to productive labor. Fortunately nearly all claimants are honest and expressions of our personal interest in their welfare will help to keep them so.

The consumer, through his courts, has been unreasonable and most destructive of the older, general, policy clauses and so has unwittingly forced policies to contain more specific policy provisions that now only the well trained can interpret. The industry must institute an educational program for its policyholders by providing contracts that are simple to read and by soliciting the support of the public in administering them on a sound, reasonable basis that conforms with the original intent.

We still have not found the solution to underwriting 'motivation', and even when we find the answer there is some question as to what we will be able to do about it except to mark the record for careful service in the event of a claim. Some equity is obtained for this factor through occupational classification, and certain underwriting restrictions, such as requiring minimal periods of residence or being actively employed for a period long enough to determine stability. An aide to underwriting the applicant is to underwrite the source. We should underwrite the agent as carefully as we would the applicant. We must monitor and control the quality of his performance because he is in position to be the most helpful, or harmful. His financing may have to change to reflect good quality and sincere service over quantity.

Inflation has been our savior in the large amount over-insurance areas, but to rely upon this consciously is very dangerous. A serious recession or depression could drop the compensation scale and what is now a reasonable benefit could become excessive. This is another reason why we must develop a true loss of earnings policy.

Tightening up on over-insurance is somewhat belated but is finally becoming a reality as companies by-pass the lower salaried market and more cautiously regulate the amounts on larger salaried applicants. Further logic on over-insurance will be introduced with wider use of benefits integrated with other disability income coverages, and benefits varying as the insurable interest varies.

Higher minimum amounts, for expense savings, and limited amounts to guard against over-insurance have forced the companies to turn to the white collar worker and the professional market to find an insurable market. There, the future indicates relatively fewer policies with much larger monthly incomes. Because of the high expense rates of small policies, and for lack of any insurable interest, the blue collar market will continue to fade away.

People in Canada and the U.S. have a better standard of living and greater peace of mind due in a very large part to the positive socio-economic effects of disability income insurance. We play a major part in the continued improvement in the pleasures of living and we will continue to this dedication. There are clouds, as we noted, many of our own making, but we understand and so there is the eternal rainbow. It is for us to determine whether at the end of that rainbow we will find a bit of gold, or a bag of peanuts.

MR. JOHN H. MILLER: As a result of developments in Social Security and trends in claim experience, which have been well aired by other members of the panel, what was formerly considered by disability underwriters to be the insurable population is now segmented into three groups. At the top tier are the professionals and upper echelon executives, managers and owners. The patronage of these higher income buyers is eagerly sought after and they are being offered monthly benefit amounts undreamed of only a few years ago. In sharp contrast, the lowest tier is either ruled out of the market entirely or limited to benefit periods of not over one year. This bottom tier is generally defined by occupational classification, by earned income, or a combination of the two. Many insurers have adopted, as a lower limit to eligibility for disability income with benefit periods over one year, a yearly income of at least $10,000, often $13,000, $15,000 or more. Our moderator has just mentioned $20,000, as an illustration.

Obviously the upper tier represents an important group of the citizenry but a relatively small percentage of all employed persons whereas the bottom tier, based on an upper income level well above the average earnings per capita, must include a substantial majority of the labor force.

This leaves, as tier 2, a large minority of the population who are considered insurable for benefits beyond a one year period, but are often not eligible for the most liberal policy conditions nor for the most favorable rating class. They are also subject to much lower issue and participation limits than obtained until quite recently, which of course is as it should be.

In my opinion, many of the steps taken were unavoidable. However, I would like to present the thought that somewhat more constructive measures could be adopted for the great mass of the public who cannot claim membership in tier 1, and especially for those in tier 3 who have been summarily eliminated from any consideration as prospects for disability cover beyond, perhaps, a one-year benefit period.

What can be offered to the millions in tier 3? Many of these of course are well covered by group plans of weekly disability income with a 6-month benefit period while others have adequate salary continuance through their employers or, if they are in one of the cash sickness states, short term coverage through the state plan. In California this may leave little room or need for supplementation. But if the industry offers nothing to the millions who are not, in one way or another, protected will there not be a resurgence of interest in state cash sickness plans, or forcefully advanced proposals to shorten further the 5-month deferment period under Social Security?

Obviously there is little appeal, to either insurer or agent, in a separate policy providing, say, a 5-month benefit period subject to a 14 or 30 day deferment period. The expense would be disproportionate to the benefits which could be paid. Could not such a coverage, however, be offered as a clause or rider in a deferred annuity policy, or in a life policy serving a remaining need for personal or family protection? This would eliminate the loading for issue expense, other than the cost of any additional underwriting required, and for separate maintenance costs. Also, with the larger premium base, the sale of such coverage might be of more interest to agents. Another area for possible supplementation of Social Security would be a policy provision bringing immediate income to those individuals who are totally disabled at the end of five months of disablement but for whom the prognosis is not entirely clear. Without supplementation through private insurance these persons may have to wait until after the twelfth month to begin to collect Social Security disability benefits.

Another problem, which is minimal with respect to tiers 1 and 3 but can be the major underwriting problem in tier 2, especially at the lower levels of tier 2, is the inflexibility of the conventional noncan or guaranteed renewable disability policy, in contrast to the bouncing Social Security benefit. I refer to the fact that a person, whether or not married, who does not have a minor child will receive only the PIA (Primary Insurance Amount) if disabled. For a person under age 30 who, for two or more recent years, has earned an amount at least equal to the Earnings Base, the PIA is $547 per month, as I calculate it. When a child is born this benefit goes from $547 to $957, an increase of $410 per month or 75% of the basic PIA. This is perhaps the most serious situation faced today by both the underwriter and the buyer of disability insurance. The underwriting problem has

not gone unnoticed, but I have not heard anything said about the problem which the consumer faces. In order to present this, I have asked Mr. Barnhart to join in a little dialogue in which he takes the role of a young man of 28 earning $20,000 per year while I take the part of an agent.

To keep my illustration from getting hopelessly complicated I will make the convenient assumption that, for all future years, sums of money mentioned will be in 1976 dollars and that an insurable person is able to increase his or her private sector disability income benefits in approximate proportion to future changes in the Social Security PIA.

At the time of this chronicle our prospect was unmarried. From the local Social Security office he learned that, in the event of total disability, he would be entitled to a monthly income of $547. It was not difficult for the agent to persuade him that he should own some disability insurance. He suggested the sum of $300 per month, which would have brought his total disability income up to 74% of current take home pay.

P (prospect): Have you brought my new disability policy in the Zenith Life Insurance Company?

A (agent): No. My company, the Zenith, is rather conservative in its underwriting. They figure that you have some insurable margin in your income today but that you are quite likely to become married.

P: No chance, but what has that to do with it?

A: Well, it would not have any direct effect on the Social Security benefit, but it might lead to your becoming a father, and then your Social Security benefit would go up by 75%, and our underwriters figure you would be seriously overinsured on that basis. Fortunately, I have a license to sell for another good disability insurer, The Nadir Life, spelled N-a-d-i-r, whose underwriters take a more generous view of issue limits. They are willing to insure you for $300 a month, benefits to age 65, under their non-cancellable policy, and I have made up the application here using the information you gave me for the Zenith Life so all you need to do is sign right here and the deposit you have already given me will be used to bind your coverage with the Nadir. If and when you do become a husband and father you will really be in good shape. With $957 tax free from the Social Security and $300 from Nadir your income after tax will be actually increased over what you are earning, all in 1976 dollars.

P: But isn't that what you insurance fellows call overinsurance? I know something about fire insurance and I understand that insurance in excess of any actual loss is not collectible.

A: You need not worry. There is nothing in the policy which permits Nadir to reduce your benefits.

P: But I do not want to be overinsured. I do not want to spend my limited insurance money for insurance I do not need, and cannot collect anyway.

A: Ah, but this overinsurance is only temporary. As short as 18 years if you have no other children and your child does not go on to college. After that the Social Security benefit drops back to the $547. And then you will surely need the insurance.

P: OK then, isn't there some way the extra insurance can be held in suspense until the time comes that I have no dependent children? Can I get that kind of option?

A: No, there is no provision for suspense. You could of course drop the insurance or reduce it in amount, but I would not recommend that.

P: Oh, come on now! If I drop the insurance won't I lose equity, and can I be sure that the insurance can be picked up again when I need it?

A: Of course you would have to pay the attained age rate when you again pick up the coverage and I cannot assure you that the company would accept your application then. You might have developed a heart impairment or something else affecting your insurability.

P: Then why hasn't your Zenith Life worked out some method of integrating their benefits with the bouncing Social Security benefit? They know all about this, don't they?

A: They have, in group insurance. The group benefits adjust to the ups and downs of Social Security and also to changes in the employee's income so that the amount of overall protection is at all times consistent with the earnings. We would like to provide the same thing under an individual policy but our Law Department feels that this would not be permitted under the Uniform Policy Provisions Law.

P: What law is that?

A: It was passed some years ago to protect the interests of the insuring public.

P: How does it protect my interests if it prevents me from buying the insurance I need on a guaranteed renewable basis or makes me pay premiums for extra insurance I do not need? Is the insurance business trying to get this law changed?

A: Not very aggressively. Our legislative counsel have been preoccupied with the tax bill, Senator Brooke's plan for optional federal/state regulation, and the abortion issue. And of course this month they are completely absorbed in following the presidential debates and assessing the significance, to our industry, of the positions being put forward by the respective candidates.

P: Well, now there has got to be some way to provide the insurance I need - there must be millions like me - under the present statutes and regulations?

A: We have the most astute actuaries ever nurtured in Cambridge, Toronto, Ann Arbor, Palo Alto or similar seats of advanced learning, and the best of Philadelphia lawyers. They have come up with a new approach to income insurance.

P: I'm all ears. Tell me more!

A: Only some rumors. The idea is to bring about coordination of benefits by simulating the group LTD flexibility. If this cannot be done in a non-can or guaranteed renewable contract, perhaps it can be done through one which is issued for a short term on a non-renewable basis, but with a guarantee of insurability for the insurable portion of the insured's earned income, as determined by recomputation, at the expiry of each term, on a consistent basis. As a buyer of insurance, aren't you really more concerned with continuation of protection in an appropriate amount than with the renewal of a rigid contract regardless of its current suitability?

P: Yes, that sounds like good sense.

A: And the new contract would also fill in each gap or hiatus in the Social Security coverage, as well as advance a percentage of the Social Security benefit when continuance of the disability through the twelfth month is in doubt.

P: How soon can I buy it? I will wait for it!

A: No, I would not advise that. It may be a long time. I would hate to see you not covered in the meantime.

P: What is taking so long?

A: It is a matter of marketing. Our marketing people do not think it will sell, not that it is not a good thing and very much in the public interest, but they do not believe that the agents would accept it. Agents and brokers of disability insurance can be turned on, they say, only by an improved or liberalized definition of disability. And there seems to be no prospect of that. We already have the Kansas City definition.

P: The Kansas City definition? What is that?

A: "They've gone about as fur as they c'n go!" But you can always count on Zenith to be the industry leader. I hear by the grapevine that there is a task force of young people working on another new concept they call Ipso Facto Disability. The idea is to list a number of diseases and pay benefits when there is a confirmed diagnosis of any one of these conditions. There is a little problem though in making up the list of diseases and so far only three have been agreed upon: surmenage*, morning sickness, and allergy to work. I sure hope they come out with this new policy. I could sell a batch of them.

P: I don't know, I like that other kind you were talking about.

*Surmenage: overwork; overstrain. (Included in Webster's 2nd International Edition, but not in the 3rd)

MR. GERALD A. LEVY: Now, more than at any time in the past there are factors present which in combination have the potential to significantly increase both the claim frequency and the average duration of disability income claim. This session has been timely in reviewing some of the major problems and their prognosis. It has started a dialogue which I hope will continue and in this context I would like to review briefly those factors which concern me and offer a suggestion to Health Actuaries.

Marketing pressures have pushed us far in liberalizing benefit provisions and raising issue limits. Social Security's liberalized definition of disability, and the significance of Social Security benefits with their built-in future increases aggravate over-insurance problems. Society's changing morality, it's attitude toward leisure and the greater stress and tension in business reduce the reluctance to make claim or malinger. Court interpretations reduce intended contractual protections and the threat of punitive damage suits cause insurers to reduce their claims conservation efforts. Consumerism and women's rights lead to more extensive coverage than companies would normally provide to females and handicapped persons. Add to these societal factors a shorter business cycle and frequent dislocations in the economy and we have the potential to cause immediate temporary or permanent changes in disability claim costs. It will take perhaps five or ten years before the effect, if any, of the above is felt. The risk is considerable for each insurer active in disability income. One long-term claim of $1,000 per month after one year of disability has cost company surplus $100,000 and after five years has cost surplus about $170,000.

What action should an insurer consider? It is a difficult question, especially if the disability line of business is a significant one. Nothing has been mentioned during the course of this session about the need to review the corporate risk exposure under adverse experience conditions to determine the potential effect on surplus. I suggest this is too important to overlook. Each company should also consider its disability income portfolio and what, if any, are the implications of these changing social and economic factors to its risk exposure.

MR. W. PAUL MCCROSSAN: Mr. Kidwell, in Canada, we do have the option of including in our contract the relation to earnings clause and an integration clause which allow us to minimize the effects of over-insurance by integrating the government benefits and other carriers. I gather that U.S. companies do not take advantage of this when they sell in Canada and I am curious to know why in view of the presentations made today about the over-insurance problem.

MR. KIDWELL: Thanks for the hint. We do not take advantage of it. In the past, we have felt we had about as pure a contract as there was on the market. In the States integration has not been permitted universally, except in group insurance. Canadian Social Insurance benefits are relatively small, and we take this into account in the underwriting limits.

MR. RODNEY C. WILTON: I was interested in a comment Mr. Hanlin made, that in the blue collar area they just sell guaranteed renewable instead of non-can. In our company we have just revamped our product and we sell only non-can now on the theory that it would be politically very difficult to increase the rates on the guaranteed renewable insurance and we would rather get a little more money and sell non-can than go through the political hassle of trying to raise our guaranteed renewable rates on policies in effect. Does Mr. Hanlin feel that they have had no problem raising the rates if they felt it was necessary?

MR. HANLIN: As you know, raising rates on disability insurance is not the easiest thing in the world when you have to prove it. You have to have bad loss ratios before the states will approve the action. We have done this though because we are very much concerned with the blue collar market. We question whether there is an insurable risk there. We are concerned about the future of social security, we are concerned about the economic conditions. Currently we are just not willing to liberalize in this market.

MR. ALLAN N. FERGUSON: Both Mr. Hanlin and Mr. Kidwell referred to some kind of screening at the branch level. I think Mr. Hanlin referred to their branch office system and I have often wondered how that system works. Do you expect your branch offices to do some pre-underwriting, do you employ some sort of persistency rating and do you use any kind of loss ratio standards? It seems to me that the volume of business that you are likely to get from any one branch office is relatively small, and that you are not likely to get any credible statistics on loss ratios. It seems to me any valuation of them must be done on a very subjective basis. I would be very interested in any comments you have to make on the effectiveness of any kind of branch screening.

MR. HANLIN: Partially what you say is true, but we only have 37 branch offices; so we are not cutting our volume up into too many different sections. Much of your screening is done by the agent who writes the business. I think we found that the answer is for our salaried brokerage managers to select, carefully, the people that they want to do business with. These are the people who are selling insurance in the "right" markets. If they do the right kind of agent selection, then we have found that the quality of the business we receive is satisfactory. Conversely, when they are dealing with marginal agents they will submit poor quality business.

MR. FERGUSON: Is that poor quality by loss ratio or are you appraising it as quality business from the occupation classes they are writing?

MR. HANLIN: We look at it both from the standpoint of what the underwriters see and also from the standpoint of excessive claims, from an examination of individual claims, not statistically. We also analyze the persistency of the business.

MR. KIDWELL: My comments were to direct your attention to do more analysis. I do not think any of our companies do enough underwriting in the field. What we do at Paul Revere is like swatting flies. We try to influence the quality of the persistency, by taking it into account for convention qualifications. We do try to weed out bad agents by looking at loss ratios, but more often by taking a clinical approach from isolated cases where the claims department or the underwriters voice concern.

MR. GLENN R. SWANICK: I have a question for John Miller. In the skit you described an ordinary product which would simulate what we are now doing in group insurance by re-rating a person every few years. I think you suggested one reason it is not on the market is that it might not be explainable to the sales force. Would another reason be that legal departments have not been able to put together a policy wording that they are satisfied with that would accomplish the desired effect? I do not know of any that

have attempted to do this. I do not see much of a problem myself, although I certainly am not posing as an expert on the law. The group definition which says '50% of earnings minus social security and other benefits' is a fairly simple matter.

MR. MILLER: Both Duane Kidwell and I have suggested pretty much the same thing. He has talked about a five year term; I have talked about a shorter term. I think his approach is excellent, if it is acceptable, but it does raise this question, "Are you permitted to reduce an existing benefit?" My concept of switching from guarantee of renewability to guarantee of insurability involves writing a policy for a specific term, I prefer one or two years, and that is it. It ends at the expiry date one or two years after issue. There is nothing in the policy about renewability but you do guarantee that, despite the insured's health, you will issue a new policy at the end of the term and you would define the maximum amount which you undertake to write for the new term. So, you would be exposed to temporary over-insurance during the remaining short period of the policy's life after something has happened to create over-insurance, but that is quite different from being exposed to age 65. This way you avoid the necessity of ever reducing existing coverage or benefits.

MR. BARNHART: John, along that line, do you see a definite need of amending or revision of the uniform policy provisions law to accomplish this or do you see a way that would permit it to be done under the existing laws of most states?

MR. MILLER: I have not talked to any attorneys about this nor with any insurance department, but it seems to me that if you write a policy providing $500 monthly indemnity, in the event of disability for a term ending 12 months from the issue date, with no provision for reduction during the 12 months, there is no problem. Then if you add a clause for guarantee of insurability, you are adding something over and above the basic short-term policy. As far as I know, in a guarantee of insurability, whether for life or disability insurance there is very little, if any, limitation to the flexibility allowed the insurer in defining the amount of risk which it is willing to pick up through a new policy. This is a personal opinion and I certainly would not express it as a professional opinion, because we are now getting into questions of law. But I see this as a more viable approach than the guarantee of renewability with a coordination of benefits provision. I do not know if anybody has tried the latter, however. I would certainly encourage an attempt at that solution.

MR. LEVY: My question is directed towards the entire panel. You have described the potential dangers to your companies from writing disability income, I wonder if any of you have investigated the maximum corporate exposure to disability claim relative to your surplus. And what that might be or if you have not explored this, perhaps you could comment on what such an exploration might include?

MR. KIDWELL: Fortunately our company is in a strong enough position that we could stand a rather substantial adverse deviation, but for a company that has a weaker surplus position, this could be a very real problem. Unless we run a simulation to better judge what is apt to happen, we may find ourselves exposing the company's surplus position to a risk that we

just cannot afford. Reserves alone are not the answer to a depression or recession. Surplus and capital are crucial at those times. This is a very real theoretical problem. It is also a concern of all of the health insurance guaranty associations.

MR. WALLACE R. JOYCE: In Mr. Miller's skit, the questions were raised as to why the insurance industry was not doing something to modify the individual policy provision law to permit the appropriate restrictions. It seems to me to be such a fundamental principle for insurance, that the payment should not exceed the loss, that this is something the insurance companies should be pressing for. I have been surprised that more companies have not tried to write contracts even within the present framework of the law that would say the monthly income payable for disability is x dollars but shall not exceed the actual loss of income. The loss of income could be defined by earnings before disability minus social security and other benefits. There is an industry committee seeking actively to promote legislation that would enable a realistic type of insuring clause that would relate payments to actual loss. Along this line, there are several companies with various types of residual policies or earnings offset clauses. Usually they relate only to earned income. Under present law the offset provision generally relates to earned income and of course not to some other benefits, such as social security.

MR. G. PHILIP STREATFEILD: We have introduced a policy which integrates to some extent, with social security. The benefits cut in half when the person becomes eligible for social security. The reduction is limited to 90% of the social security benefit and we have that approved in all States except Tennessee and Maryland.

MR. ROBERT P. COATES: May I talk just a little bit about the policy provision law from the viewpoint of a record in medical care insurance. The Equitable introduced, in 1961, a major medical policy that coordinated with other insurance. We were able to get it approved in all States under a provision of the law which I can no longer quote. In substance it says you can alter the standard provisions if they do not fit your benefits. There might be a little more flexibility there than some of you gentlemen anticipate. I am not saying we did not have to make some trips to different states and argue it, off and on, over the years. It is a close point, but our lawyers believe we have a very good position and we are still selling our policy.