RECORD OF SOCIETY OF ACTUARIES
1977 VOL. 3 NO. 2

LONG TERM DISABILITY INSURANCE

Moderator: WILLIAM J. TAYLOR. Panelists: JOHN C. ANGLE, BENJAMIN F. JONES, W. DUANE KIDWELL*

1. Disability Experience.

2. New Benefits.

3. Underwriting Rules.

MR. TAYLOR: Welcome to the concurrent session on disability income. We have assembled a panel of distinguished experts on this subject who are looking forward to a spirited discussion after their prepared remarks.

John Angle, Senior Vice President and Chief Actuary of the Guardian Life, will lead off with a history and survey of the market, and then tell us about the Social Insurance Supplement Rider introduced by the Guardian in April, 1977. Our guest, Ben Jones, President of the Monarch, will concentrate primarily on the overinsurance problem and will fill us in on some exciting developments at the HIAA. Incidentally, these have come about primarily as the result of his efforts. Our anchor man, Duane Kidwell, Vice President and Senior Actuary of the Paul Revere, will tie it all together by describing in some detail a product which addresses most of the problems plaguing the industry.

If you will hold all of your questions and comments until all panelists have given their prepared remarks, we have reserved about one hour for what we hope will be a free-wheeling discussion.

MR. JOHN C. ANGLE: The philosopher Hegel once wrote: "What experience in history teaches is this — that people and governments never have learned anything from history or acted on principles deduced from it." It would be the thesis of your panelists today that there is still time, though precious little, for insurers and governments to learn the principles of disability insurance. I say principles advisedly for it is my view that no single cause underlies the problems before us and that no single, simple solution will return disability insurers to financial health.

Ten days ago U. S. President Carter called for the total reform of the welfare system. Because I found his public message to provide such striking analogies to the issues confronting disability insurance I want to read to you five of the principles that President Carter proposed to guide welfare reform:

1. Every family with children and a member able to work should have access to a job.

2. Incentive should always encourage full-time and part-time private sector employment.

* Mr. Jones, not a member of the Society, is President of Monarch Life Insurance Company, Springfield, Massachusetts.

3. A family should have more income if it works than if it does not.

4. The programs should be simpler and easier to administer (than they are now).

5. There should be incentive to be honest and to eliminate fraud.

Not much argument about those principles, is there? The difficulty comes, as President Carter and HEW Secretary Califano found, in converting principles to programs. In fact the going is so slow that the President concluded that:

> "A most important, unanimous conclusion is that the present welfare program should be scrapped and a totally new system implemented . . . . (the) many separate programs taken together still do not constitute a rational, coherent system that is adequate and fair for all the poor. They are still overly wasteful, capricious and subject to fraud. They violate many desirable and necessary principles."

The complex dysfunctions of disability insurance, like those of the United States welfare system, are interrelated to changes in adjoining systems. Some of the more noteworthy changes include the incredible growth in the Social Security Disability Insurance since 1956, the merging of courts of law and equity in the United States judicial system, rising expectations, the rise of group disability insurance and finally, for some insurers, the seemingly irrational stretching of the his-occupation definition of disability.

There were few signs in the early 1950's to indicate that 1977 would find individual disability insurance holding less than ten percent of the "market" for long-term disability insurance. And that even that ten percent sector would be shared with the United States Social Security system. Under a 1956 amendment to the Social Security Act, disability insurance was extended to virtually every one of the 90 million employed persons in the United States. In 1974 OASDI paid over seven billion dollars to well over 2 million disabled persons. The count of disabled beneficiaries reached 2.7 million by the end of 1976. OASDI benefits have soared in size since "automatic adjustment provisions" were incorporated in the act in 1972.

Second place in the long-term disability market has been taken over by group disability benefits. HIAA statistics suggest that group long-term disability benefits covered 11.5 million persons at the end of 1975.

What about individual long-term disability insurance? Seven million people carry what are generously defined as long-term contracts and pay premiums which cannot exceed one billion a year.

It apparently took a business recession to expose the financial consequences of these major shifts in the long-term market. I can illustrate this from a tabulation we recently made of the operating experience of some fifteen of our competitors. Twelve of those fifteen companies (and The Guardian would make thirteen) suffered a loss from operations, after crediting investment

income, in 1976. Some, furthermore, have had clear difficulty in establishing adequate loss reserves which seems to signal a decline in claim terminations from death and recovery. The median operating position was held by a company that lost $1.65 million in 1976.

So much for this brief history and survey of the market. Let me now turn to an example of the sort of innovation and change that I expect the immediate future to bring. In particular I will describe the features of the Social Insurance Supplement Rider introduced by the Guardian in April, 1977.

The Guardian's SIS rider can be written in an amount equal to what the insured can expect to receive from Social Security disability benefits. In most cases, this amount is close to that payable under a no-fault auto insurance claim or under workmen's compensation. The balance of the prospect's needs are insured under the policy to which the rider is attached.

The SIS rider benefits are payable for any period of total disability for which the insured qualifies for benefits under the base policy and so long as the insured is not collecting disability benefits under social security, workmen's compensation, or no-fault automobile insurance. Both rider and base policy carry the same elimination period and maximum benefit period. Benefits cease under the SIS rider when the insured actually receives his first benefit check from social security, no-fault or workmen's compensation. In any event the insured is not required to return Guardian disability payments for the span of months prior to receipt of that first social security check.

Full credit for the creation and designing of Guardian's Social Insurance Supplement Rider belongs to Mr. Gerald S. Parker, CLU. All actuarial phases of the project were directed by Mr. Eugene Dorfman, FSA. Mr. Dorfman describes the rider as a joint contingency disability income insurance. The first probability entering the joint contingency is that an insured is alive and disabled, by our definition of disability, at the end of any month following the end of the elimination period. The second item is the probability that the claimant does not receive a disability payment from social security, no-fault auto, or workmen's compensation in that month.

With the introduction of the Social Insurance Supplement rider, the Guardian substantially reduced the amount of basic long-term disability benefits that it would issue in most income brackets. I can best explain this change by illustrating our issue and participation limits for four levels of monthly gross earnings:

$ 1,000 of monthly earnings:	$50 per month of base policy benefits and $550 per month of SIS rider benefits.
$ 3,000 of monthly earnings:	$1,150 per month of base policy benefits and $700 per month of SIS rider benefits.
$ 5,000 of monthly earnings:	$1,900 per month of base policy benefits and $700 per month of SIS rider benefits.

$10,000 of monthly earnings:	$3,200 per month of base policy benefits. The SIS rider is not available to applicants earning $10,000 or more of monthly earnings.

These limits assume average federal income tax rates and ignore the variation in social security benefits by age. The limits are reduced for applicants with substantial investment income. While we seek to replace no more than 80% of an applicant's after-tax income, we are aware that these limits replace closer to 90% for those with up to $3,000 of monthly earnings before-tax.

The SIS rider may only be the first step in a more radical adjustment of individual disability insurance coverages. Mr. John Miller has recently been saying that disability insurance more closely resembles bodily injury and other casualty insurances than it does life insurance. The past now offers less of a guide to the future than it has for a third of a century. The uncertainty is even greater for such untested coverages as his-occupation to age 65, or some forms of residual disability insurance.

All of this increases the importance of gathering more statistics on disability experience. United States actuaries now have a highly personal reason for analyzing the experience of their clients or employers. Under a 1975 change in the life and health annual statement blank, United States actuaries are now required to render an opinion as to the appropriateness and adequacy of health insurance reserves. Applicable financial reporting principles require the actuary to use assumptions appropriate to the specific circumstances of each company. Furthermore, the valuation assumptions are to be adjusted for expected trends in the light of economic or social developments or other extraordinary influences.

Actuaries giving such opinions may wish to ask themselves if the definition of disability can be ignored in predicting future claim costs. Can it really be that the his-occupation to age 65 will produce claim costs equivalent to those of a total and permanent definition of disability? In circumstances in which an actuary recommends a more stringent standard than the statutory minimum, he should bear in mind the possibility of premium deficiency reserves.

I suggested last week at a seminar sponsored by LIMRA that the business may be turning full circle with the prospect that the individual long-term disability business will become concentrated again in a limited number of specialty companies. I suggested that the survivors would be those willing to maintain a strong, well-qualified staff of full-time disability insurance people, and those willing to do what's right regardless of the competitive vogue or fad of the moment.

MR. BENJAMIN F. JONES: I started selling disability income insurance in 1947; and during the next 20 years, I do not recall hearing a discouraging word about the future of the business. It was solid as a rock, claim problems were virtually nonexistent, and during those years the Monarch paid claims promptly and generously. As a result, our Claim Department was acclaimed by our field force as its most popular division. In fact, the continued profitability of our disability income portfolio was the only justification for continuing to offer individual major medical coverage, a

line of business on which we experienced continuously increasing loss ratios.

In 1968 for the first time, our disability income experience faltered. From then on profit margins eroded year by year, and by 1973 we incurred our first underwriting loss in over 50 years of offering individual disability benefits to the American public. This prompted us to make a thorough investigation of this product line. To augment our studies, we sought the advice and counsel of three independent firms. A number of remedial programs were recommended.

They included: more intensive agent and general agent training, more stringent financial underwriting, across the board rate increases, modified issue and participation limits, increased waiting periods, discontinuance of certain marginal products, reclassification of certain occupations, elimination of certain occupational classes, refusal to offer residual benefits in conjunction with the "his occupation to age 65" definition of disability, revised earned income limits, and major changes in claims control techniques with emphasis on early intervention and rehabilitation.

We implemented all of these recommendations and they had, as you might suspect, a rather negative impact on our sales organizations which resulted in an overall reduction in our marketing vitality. Our results, however, continued to deteriorate and our search for causes continued.

Then, out of the blue, I received a phone call from a claimant complaining about a decision by our Claim Department to discontinue his disability benefits. Subsequently, I looked at the file and found:

1. The individual's earned income before disablement was approximately $45,000 pretax, after deducting business related expenses.

2. He was issued $2,000 of monthly disability income benefits by the Monarch.

3. In the year prior to disablement, he had acquired an additional $5,000 per month of long-term disability income coverage from two other writers.

4. He had also qualified for and received $1,000 per month of group long-term coverage.

5. He also qualified for Social Security disability benefits.

Thus, his total tax-free benefits were over $100,000 per year, as compared to $45,000 before tax prior to disablement. I was stunned for this was the first clear-cut example of gross overinsurance that I had seen.

This case resulted in an exhaustive examination of our files to determine the extent of overinsurance. That study showed that far too many of our claims having the largest reserves had two things in common: (1) the disability did not warrant total inactivity, and (2) there was no apparent financial incentive to return to work. Independent medical examinations, inspection reports, and personal visits by our claim people were not productive. The more we looked, the more we realized that we had created a

uniquely valuable property capable of providing long-term financial security to persons who were not seriously disabled, but who recognized the extraordinary value of payments under a disability contract that were tax free.

We believe that we have made two serious errors in the development of our long-term disability portfolio. First, the contract language and policy provisions result in a document that makes it extremely difficult, if not impossible, to refuse to pay a questionable claim or to effectively defend that action in court. Secondly, we did not fully appreciate until very recently the impact on our own loss ratios of the benefits from other systems of compensation that were available to our insured.

We had developed a plan which is near perfect to present at the point of sale -- almost unmanageable at the point of claim -- and as a result, had suffered substantial and unexpected losses without knowing why. No one was keeping score. If the contestable period had expired, there was nothing that could be done anyhow. The insured said he was disabled; his personal physician confirmed it, and while the great majority of disabled people are legitimately in that category, there are others who intentionally or otherwise found themselves in a position where they could leave the job market for less serious medical reasons and not return to active employment until fully and completely recovered. There were still others who found themselves in a position of having to make an actual financial sacrifice in order to return to an active business life, and so they, in effect, retired.

These various compensation systems frequently overlap providing more benefits than are reasonable with respect to the loss incurred, and as a result, the financial soundness of the voluntary and mandated systems is placed in jeopardy. It is essential that an effective overinsurance provision be developed if the individual, group, and franchise writers are to continue to offer long-term disability income benefits to the American public.

In February, the Health Insurance Association of America Board of Directors called for a special meeting of the Chief Executives of member companies who were writing individual and franchise disability income contracts to determine what action might be appropriate for the HIAA to take at this time with respect to this problem. That meeting was held May 3 in conjunction with the Annual Meeting of the HIAA. Those present believed there was strong evidence suggesting that overinsurance was contributing to the rising cost of providing loss of time benefits, and that such overinsurance was contrary to the public interest.

They recommended that a special committee be appointed to study and measure the extent of present and potential overinsurance and its effect on costs to the public. They requested that an examination be made of viable techniques which might aid in the development of a solution to this problem.

It was apparent to the HIAA Board and to the company officers who attended the May 3 meeting that this subject was extraordinarily complex. It would be a challenging task to draft an effective overinsurance provision which would be reasonable, and in the public interest. All felt the effort would be worthwhile, because in solving the problem our industry can continue to meet the needs of those persons in our society who must work and are continuously exposed to the risk of not being able to do so because of an

illness or accident.

This committee will need all the help it can get in developing persuasive inferential data and information from every source to examine the premise that overinsurance is primarily responsible for the adverse underwriting losses which our industry has been experiencing during the past five years. This first step is absolutely essential, for without it, we cannot expect the support from companies, their field forces, consumerists, regulators, legislators, or the American public.

The Society of Actuaries can play a major role in the development of critical information, as well as assisting in the creation of a viable technique which will substantially reduce and perhaps eliminate the adverse effect which overinsurance has in providing disability income protection. I sincerely hope that individually and collectively you will address yourselves to these problems.

MR. W. DUANE KIDWELL: Let's try to design a product for today's narrower, essentially professional, market, price it for future exposure, and prescribe plans to police it. You might guess that if we were to stick inflexibly to building a perfect policy from the actuarial point of view, we could end up with a lengthy, complicated, impractical contract. Accordingly, we should be as practical as possible in designing such a policy, as will help to illustrate our salient points.

Insuring Clause. The insuring clause should have a simple definition of disability that would fulfill our intent to cover an amount of spendable income that could actually be lost in the event of continuing disability from sickness or physical injury. We do not intend to insure occupations by narrow job type definitions or to promote early retirements. Appearing with increasing frequency, claimants under the his own occupation clause are closing up shop early in a period of disability, apparently getting ready for the long haul retirement claim. Accordingly, we would use only a short (say one year) period of his own occupation, to encourage early plans for rehabilitation. Income received from any source other than investments after the onset of the disability should not be considered lost income and would not be duplicated by the policy.

The concept is simple but it would be difficult to administer, and there is the argument that straight offsets are inequitable. Therefore, each year, or less often as is practical, the insured would be asked to voucher an insurable income for the period immediately following and he would then be billed accordingly at the original age rate. The voucher would be contestable insofar as income is concerned in order to promote honest reporting, and the amounts of indemnity would be limited to increases of no more than 15% with any one voucher in order to discourage antiselection. The amount of spendable income could be defined as the applicant's net after-tax earned income less local and FICA taxes. If the husband and wife are both working, we would prorate by some method to determine the applicant's portion of the net income.

The applicant could choose to buy our policy for any amount up to 60% of the spendable income, less available social security, nonintegrated group, and individual disability income benefits, at a basic rate. This would allow 20% for personal expense reduction and 20% for coinsurance to keep the premium low. If he wished to exceed this 60%, the base rate for the whole

package would be higher (perhaps as much as 25% higher). This higher rate would be necessary because claims that would normally run for three months with reasonable coverage, will run for four months with more adequate coverage, and for five or six months with excessive coverage. Accordingly, even then, because of this heavy selection against the company, we would not permit insurance of more than 80% of spendable income, less all other available insurance. We would have a cap of $4,500 per month from all sources including social security. This cap would be varied from time to time as inflation continues. It should be a family cap if both husband and wife are working.

We would not pay benefits if the claimant is receiving unemployment compensation. The company would pay an amount equal to the benefit insured while the claimant is totally disabled, plus any social security benefits not otherwise payable. Thereafter, spendable income lost would be vouchered periodically at the company's discretion. To obtain the current amount payable we would start with the amount of spendable income last determined insurable and deduct 60% of the current gross earned income. We would also deduct any other disability insurance benefits, but not less than those declared in the insurance voucher, and would deduct any retirement or social security benefits received. The payment would be the same percentage of this net amount as was originally insured.

Our benefits should terminate at age 65, the normal retirement age. A shorter, 5-year benefit period may be offered to those who choose to coinsure by length of claim, and to otherwise carry the full affordable amounts. The policy itself should terminate at age 65 or, in any event, upon receipt of retirement benefits from employer or social security.

Elimination periods, benefit periods, and indemnity benefits for accident disabilities will be the same as for sickness disabilities because of the increasing inability of the public and the courts to distinguish between the two.

People are quite mobile today and becoming even more so, making the handling of claims by remote methods a growing problem. Accordingly, we will suspend claim benefits for any period during which the claimant is not available for reliable medical control.

Pricing. There are different levels of morbidity for any given population. In particular, there is a level for people who are underinsured and a much higher level for those who are overinsured. The industry has gone from an evolution of underinsurance into a present and future of overinsurance, and it is the effects of this transition that we have been observing in the vanishing profit pattern. It is doubtful that this transition period is over or will be over for another four or five years as we watch the 1970's policies mature and as we adjust to new underwriting and claims techniques that are required to handle this affluent population.

It will be difficult to find reliable morbidity statistics for pricing. Very little has been published, not because of competitive concerns, but because there is not sufficient homogeneity in the data. We would make such empirical adjustments to our own company experience tables as would, in our opinion, estimate tomorrow's experience from our data from historically different insuring clauses and economic conditions, changing work ethics, and improving health care. There should be separate tables by sex,

occupation classification, and elimination period. Calculations should reflect further deterioration in claim costs of 3% to 5% per year for a few years as might be expected from medical techniques improving the chances of survival and as would be expected from improving standards of living and continuing changes in work ethics. Claims handling expense will grow with inflation even while the insured is on claim and we must reflect that in the claims cost. Any select period reflected in the morbidity would be very short (two or three years).

The actual premium billed would, of course, be in two parts. The first part would be for the basic amount of insurance requested and the second part would be based upon the amount of benefit vouchered for social security. This latter part would be calculated by starting with base unit and deducting the cost of the social security benefit to get the premium.

A rather major problem is our inability to compile data as early as needed for the volatility of the business and to react quickly to changes or trends. Long rate guarantees and the delays from state reviews of rate filings are not in harmony with timely response. Accordingly, our contract should be renewable every five years. The initial set of rates per $100 of indemnity should be conservative and be included in the contract with provision for reductions (for a noncancellable contract) according to company experience as filed with the commissioner to assure the prescribed loss ratio. The initial sets of rates could be filed for approval with a performance scale to obligate us to vary renewal rates downward, if appropriate for changing morbidity experience, without the need for additional approval. The schedule would allow us to offer a smaller initial premium and a higher ultimate premium that is more in line with the professional man's ability to pay. The short renewal period and low premium would make it easier to validate legal minimum loss ratios of 55% to 60% safely. It would permit earlier assessment of the major results from a block of business, and so be more acceptable to modern accounting methods. The approach is easily adaptable to guaranteed renewable policies (i.e., policies without a guaranteed premium) as well, since the method could be extended to either increase or decrease rates on renewal.

Interest rates for any five year period are of a very long range nature because, in the event of a claim, premiums already paid must establish the claim reserves for the long pay out. Interest rates for successive renewals are both deferred and long range, so we should grade interest rates downward slightly for successive renewal periods as the charge for the deferred investment risk. The active life reserves for our policy would reflect the step rate nature of our premiums structure and the heavy active life reserve accumulations of a level premium non-can to 65 policy will be avoided.

Elimination Period. Elimination periods will be for at least 30 days of disability. Shorter periods of disability should be adequately covered by savings or salary continuation plans and in any event amount to less financial strain than a vacation. Furthermore, high volumes of short claims are impractical for pricing, being relatively expensive to handle and subject to greater ease of antiselection.

Expenses. Maintenance expenses should be expected to increase from year to year with inflation. These would affect the per policy unit costs particularly on voucher reviews and upon renewal.

Renewal expenses will be kept to a minimum by using a maximum of head office correspondence and requesting agents to make awareness phone calls to offer reassurance and to encourage persistency. The agent will then be paid renewal commissions as for a service call, higher than the usual renewals but still far less than a repeating new business schedule.

The high cost of marketing and issuance associated with high lapse rates and replacement rates has been nearly as significant in increasing the cost of disability insurance in recent years as has morbidity deterioration.

Good persistency must be encouraged through fairness and awareness to the public and penalties for deliberately rolling over contracts without a very good cause. The same replacement laws, in my opinion, should apply to disability income that apply to life insurance.

Underwriting. We cannot overemphasize the importance of the agent as a field underwriter or of a claims man as an agent underwriter. The salesman's ability to screen and willingness to evaluate clients is a most valuable asset to himself and to the company. Underwriting treatment both in service and in decisions will be very heavily influenced by the opinion the head office has of the agent's business in general. The agent, the underwriter, and the claims examiner must operate as a close team. The significance of just one bad claim is so very real when we consider that it takes the expected profit and contingency margin from 200 honest policyholders to support one bad claim. This same bad claim could cost 50 honest people $100 per month each in extra premiums for as long as the claim is extended.

We must be sure that agents fully inform the policyholder of the value of and the limitations of their entire loss of income insurance programs as a follow through on sound underwriting.

Claims. Our claims handling must also have attention. Amounts of indemnity under our new policy would be very large with the possibility of a claim of more than $500,000. We can, therefore, afford tight review and surveillance to reduce the admission of bad claims and to encourage early rehabilitation. Our training manual should promote consistency in claims handling, taking some decisions off the claims examiner and pointing out problem areas that could develop and areas that might be considered an unnecessary invasion of privacy. Closer monitoring by phone and in person will provide better service and help to keep abuse within bounds. Our obligation and our dedication is to serve the honest claimant promptly and courteously.

The last thing a disabled person needs is harassment in supporting his claim. Most of our expense and all of our problems arise from handling the very few who would be dishonest or lazy. These are the people who are quick to interpret benefit entitlement as a legal question rather than as a medical right.

We have now developed a broad solution to a better policy -- a simple policy to insure lost income, to permit quick reaction, and to accommodate current accounting.

We have talked about the major features that need to be considered when building our policy, but we should also, for the good of the industry and the public, work hard to promote legislation in two very significant areas:

a. to promote reasonable court consideration of malpractice, punitive damage, and pain and suffering awards.

b. to put a lid on social security disability income benefits at the beginning of a claim that will not permit them, together with all other insurance, to exceed 80% of the net after-tax earned income from the last taxable year preceeding disability.

I have the utmost confidence that as soon as we settle down to offering a sound product at a fair price our sales force will be fully as able to handle the marketing in the future as it has been successful in handling the more client motivated sale of the past.

MR. DALE S. HAGSTROM: Mr. Kidwell has shown how complicated an individual disability income policy would be if we tried to solve all the problems of disability overinsurance strictly through the individual contract. The primary problem with such a solution is that benefits would be reduced, while administrative expenses would be increased. A secondary problem with the solution is that it is politically impractical; on the surface it serves only insurance companies.

Perhaps one practical alternative would be to change the federal income tax laws. If premiums were made tax deductible, then the benefits could be made subject to income tax. In particular, disability benefits up to an amount equal to earnings prior to disablement should be taxed as earned income. Disability benefits in excess of earnings prior to disablement should be taxed at a 100% marginal rate. This severe tax can be considered a windfall profits tax on income neither earned nor economically justified. Disability benefits should include both premium waiver and income benefits, including Social Security benefits. Possibly, if justice were thought to be more important than simplicity, the earnings level at which the 100% marginal tax rate is applied could be linked to the Consumer Price Index.

There are a few arguments to support this proposal:

1. The financial reward for misrepresentation to obtain overinsurance will be removed.

2. The additional income to the General Treasury from the windfall profits tax can be used to pay for the subsidization of Social Security inherent in making Social Security taxes deductible for income tax purposes.

3. The proposal addresses the problem of potential overinsurance already on the books; although, it need not be applied to people already disabled.

4. The tax-deductibility of premiums will encourage those who lack coverage (essentially individuals not working for large corporations providing group insurance) to purchase the coverage they and their families need.

5. The proposal that the 100% marginal tax rate be imposed only at the inflation-adjusted income level prior to disablement

does leave some incentive for a return to work. The three mechanisms to this incentive are the progressive nature of the income tax, the potential imposition of state income taxes, even where the federal income tax marginal rate is 100%, and the fact that productivity gains combined with inflation-related salary gains are more attractive than simple inflation-indexed gains.

MR. RICHARD W. KLING: Recently in reviewing a large claim I came across a number of interesting facts. In the original application, the individual disclosed that he had disability insurance with another carrier, but that it was intended to be replaced. However, on his claim form the individual noted that he still had coverage in force with the other company. The total of the two coverages was well in excess of his gross income. Since the claim was within the contestable period, I asked our lawyers if there was any way to deny this claim, since there appeared to be a misrepresentation in the application. The answer I received was no, since the replacement statement in the application was based on the insured's intent.

This type of situation could be of serious consequence to us, since I estimate that 10-20% of our business might be of the replacement type. I am wondering if the panelists can answer two questions for me: (1) Is there any possibility that you do have a case of misrepresentation in this particular instance, and (2) what do you do to assure that you don't have overinsurance in a replacement situation?

MR. JONES: I'll take a shot at that first question. My company's practice has been to go after those type of claims. We believe that if the individual states on the application that he is going to drop the other coverage and he subsequently doesn't drop that coverage, then we should have a case against him. However, I believe the odds of winning such a lawsuit are not very good. Let me tell you why. Replacement practice in the industry is very bad. In some cases the agent will inform the applicant that all he has to do is drop the existing coverage for 24 hours, then the agent can legally issue an amount up to the participation limit. The applicant can then reinstate the other contract. So, even though the applicant said he would drop the existing coverage and didn't, his defense is that it is the industry's practice to allow this dropping and reinstating of coverages and he didn't want to go through that formality. It seems to me that all the disability insurance you may want to buy is available to you. The reason for this is that agents are anxious to sell it, and because companies do not stop the rollover. The rollover question that the other panelists have referred to is really a problem because that's the way agents make their living. As to your other question, I don't know. I wish there was a replacement law -- we would all be better off.

MR. KIDWELL: We have proposed that after three months the agent be required to follow up on a case to see if promises to drop coverage were fulfilled. As you would expect, the salesmen expressed concern and we withdrew the proposal. I think there should be follow-ups before claims occur but I do not know of any company that has such a program. Perhaps someone in the audience would address the question for his company.

MR. JONES: We do it by letter and a letter comes back with a signature that looks alright, but you don't really know whether he has actually replaced it

or not. Let's face it, if he wants to find more disability insurance and his goal is to have his estate planned properly for disability, he will find a way to do it.

MR. HERBERT ORENSHEIN: On the replacement question, one possible solution might be to state in the contract that in the first 90 days of coverage it is renewable at the option of the company. In that way, the company could then follow up within the 90 day period and cancel that policy if the individual has not dropped the original coverage.

MR. HAROLD G. INGRAHAM: I have two questions to the panel. First, do any of you think it is possible to get a policy form approved with the coordination of benefits clause in it? The second question relates to group bill discounts which some other companies are now using. These are discounts where if you have at least x lives in the billing group, then they discount off what would otherwise be the manual premium by some percentage, say 10 or 12%. I fail to see any justification for that other than the fact that it is a good marketing gimmick. You can't really say that your persistency is going to be better, or your morbidity, or that you are going to save any money. I wonder if the panel has any thoughts on whether my thinking is correct, or is there really some justification for this group bill discount idea?

MR. JONES: In relation to your first question, I think it's going to be extremely difficult to get an adequate coordination of benefits provision through the state legislatures. The main roadblock is the fact that the individual has paid his premiums and now at the time of claim he wants his benefits. This is the sort of thing that the HIAA committee is going to be talking about. We are going to look at every idea you can think of. Mr. Hagstrom mentioned federal income tax modifications. I think it presents a very interesting area because it speaks to the existing book of business. I think that the new policy lines are going to be terrific, but it doesn't do a thing for the business that we already have on the books. I think we can get a coordination of benefits clause approved, and to that end this committee is going to work like the dickens. As to your second question, I don't know who started the group billing discount idea, but one of the problems you have is that field forces always insist that if you go into something, you go into it at the top of the line. So they want all of the discounts and gimmicks that their so-called competitors have. As I have said in my prepared remarks, this is terribly important to their way of life. They want to talk the hottest product, the hottest residual, the finest this, and the best that. Our entire sales presentation has gone to contract language as opposed to needs. It creates some very difficult problems in this whole area.

MR. KIDWELL: We do sell products on a group billing mode and did offer discounts. The discounts were certainly not justified by savings in expense, morbidity or persistency but, really to meet competition. We have recently reconsidered this approach and our current series of policies are more equitable by premium mode. We currently charge the same rates for group billings as for preauthorized check modes. The negative impact on this type of sale has been quite significant.

MR. ANGLE: Several years ago the Guardian tried to file a group disability policy in which we wanted to coordinate every benefit in sight, including any individual disability contracts that the insured might have. What we

found out was that several states specifically prohibit this. New York's Regulation 62 is an example, which spells out the coverages that you can coordinate group disability coverage with, and you can coordinate them with everything except individual contracts. I seem to remember that we got the same answer from California and several other states.

MR. ORENSHEIN: I have a comment regarding the overinsurance problem. As I understand it, in Canada the Workmen's Compensation Board has a program whereby they carefully follow-up shortly after the person is disabled to try and find an occupation for which he is now qualified. If he is qualified, he is required to work, or attempt to work at the new occupation. Failing to do so, his Workmen's Compensation benefits are cut off. If we could apply the same idea to the Social Security program, it might result in a definite improvement as far as claims malingering is concerned. It would definitely benefit the insurance companies because the person would be either not overinsured or less overinsured, and it would have an immediate affect upon all policies that are in force.

MR. W. PAUL MCCROSSAN: My question is for Mr. Kidwell, and it's one I asked last year in Toronto. At that time he delivered a speech on a panel with John Miller, and I think he pointed out the tremendous overinsurance problem, and the fact that states, such as New York, prohibit offsetting one coverage against another, or bringing in government benefits. In Canada, you can have both an integration and a relation to earnings provision, where you can include government and other insurance benefits, and relate them to 100% of salary up to the time the disability is incurred.

Our company does have this provision in our policy. The Paul Revere agents seem to be rather successful in implying that we are a little crooked by having these restrictions in our policy. I was wondering when he was going to get around to solving this problem in Canada, where he can legally do so.

MR. KIDWELL: I remember that exchange last fall, and we have discussed this at Paul Revere. Although Canada permits integration, the problem is not nearly so accute as in the U.S. Furthermore, the policies would be less competitive and more difficult to sell. Accordingly, we have temporarily rejected the possibility of an offset benefit in Canada. The need is much more serious in the U.S. and the problem will be solved soon, I hope. At that time, it will be logical to consider an adaptation for Canadian contracts as well.

MR. MCCROSSAN: It seems that the field's reaction to every restriction is that it won't sell, but our experience in the health business has been one of expansion. I would say that we have been growing at about a 50% compound rate in Canada, with very good claims experience. I don't really attribute the good claims results to the existence of the clause, but perhaps to the moral suasion point that if the clause is there, you deter the policyholder who is thinking of ripping you off from buying in the first place.

MR. WILLIAM M. ROTH: The group insurance operations seem to be writing long-term disability insurance profitably now. They have a lot of built in advantages. Does anyone foresee any problems with group long-term profit results?

MR. TAYLOR: We don't have any group representation on the panel here. From the grumbling I hear from our own Group Department, I would say that they do

have some problems, although not as severe as on the individual side of the fence. Does anybody in the audience care to respond to this question?

MR. FRANK J. BUSH: I'd like to comment on the group experience, but first let me say a few words concerning the Society of Actuaries morbidity studies. Up to about two years ago, I had been Chairman of the Society's Committee on Group Life and Health Insurance. Most important of the current studies is the group long-term disability study.

I would suggest to Mr. Jones that the Society studies are a great vehicle for quickly compositing the results of companies with pseudo-like plans and coverages. However, more individual company support at the executive level is needed to assure the continuance of these studies on a meaningful basis. I notice from my experiences with the intercompany committee work that many of the companies, if they are not dropping out entirely, certainly aren't increasing their contributions commensurate with their volume increases. This is largely because the executive level isn't willing to absorb the extra cost necessary to support the contributions to the studies. So I would suggest that this is definitely an area that could be explored.

As far as the group experience is concerned, we have tools that are at our disposal that obviously are not available to the individual line. Our rates are generally guaranteed for only one year, so we can correct an existing book of business quickly by turning it around with rate increases. Also, the LTD experience is generally combined with that of other coverages for dividend or experience rating purposes. We also have a policyholder, namely the employer, who has a real interest in the group's experience. When he sees his dividend margins invaded on the total case as a result of one or two bad claims, hopefully we can depend on him to exert some pressure on the individuals as far as getting back to work at an earlier date. We do not have the field opposition from the agency side that the individual line has. Thus, we can be a bit more hard-nosed in suggesting changes which have to be made because of the bottom line consideration. We did turn around, in large part, most of the deterioration that occurred in the first phase of the recession - the 1969-1970 phase. The intercompany group statistics also alerted us to the poor results due to the 1973 recession which we are now coming out of.

The thing that amazes me in listening to this panel today is that you have left me with the impression that the individual line got caught with its hand in the cookie jar, so to speak. It has a handful of what was remembered as tasty and desirable goodies from past years and instead of letting the hand slacken and letting a few cookies drop out, it seems to be screaming for outside help, including bringing the government in, an almost unprecedented course of action. I'm somewhat surprised that you don't have more resources available to correct your present book of business - perhaps it's due to my lack of knowledge concerning your product. I would be interested in knowing what proportion of your business could be corrected by aggressive renewal underwriting and rating action, for instance, and why that isn't being done, even though it's obviously not the most favorable position to take from the agents' viewpoint.

MR. JONES: If I may, I would like to respond to your question because I believe you are right on target. We have had our hand right in the cookie jar, right up to the elbow. We very reluctantly have been willing to drop one little cookie and I think that's an indictment of the leaders of the

disability income business, of which I think my company has been for a long time. We simply didn't know what was causing our trouble. We racked it up to every single thing you could think of except the one thing that counted - that is, the unmotivated claimant. He's the guy who says "Look, I've got enough of this world's goods, and I'm not going to go back to work. I've got your group long-term and I've got these other systems of compensation that are all pouring money into the family coffers, and this is my new occupation."

His new occupation is staying sick. He doesn't have any trouble at all getting a physician because he can search until he finds one that says "Yes, you are disabled." To do otherwise, the physician may get himself nailed on a malpractice suit, specifically, if he allows the individual to go back to work when he is not ready to go back to work.

It is true that part of the beating that we as disability insurers have been taking can be attributed to our own stupidity regarding residual definitions of disability, own-occupation clauses, and low premium rates. These are things which we should be able to protect ourselves against. However, we can't protect ourselves against the phenomena of excess coverage. The 1950 standard provision just won't work. It simply will not solve the problem of the individual who says "I'm going to get enough disability income insurance so I can step out of this rat race."

In 1975 we paid claims on two agents for call reluctance. They didn't want to make any more calls to sell insurance. I don't know whether that surprises you or not, but I'm telling you there is not a single thing we could do about it. One of the claims was on an agent for another company who bought our coverage. He obtained medical evidence that it was upsetting him - making him nervous to do business. Sure he's nervous, because making calls are no fun, but the real reason for the claim was that he had systematically purchased approximately three times his net income in disability benefits.

Monarch last year had about a million and a half less premiums than the year before, and our agency force was cut by 25% of our career agents, because we're not a leader anymore. We simply won't do it. But, if we can get legislative relief on what is truly not in the public interest - that is, letting an individual obtain more than his gross income in disability insurance, I think the rest of the problems will straighten out.

MR. ANGLE: Let me add one point, if I may. Premiums on individual disability income policies are subject to rate regulations, specifically with regard to loss ratios. There have been difficulties with states that are looking at loss ratios based on total premiums, both earned and unearned. It is obvious that for a company with a large proportion of business in the first few policy years, such loss ratios will be well below the desired 50%. It's like looking at the second year claims on an ordinary life policy and finding that your claims are only 6% of the premium. The proper comparison should take only the earned premium into account. This is being addressed to some extent by a committee which is doing some work for John Montgomery, the Chief Actuary of the California Insurance Department.

MR. TAYLOR: I think there is plenty of blame to go around on this particular subject. Certainly the Congress deserves their share for providing a large percentage of the population with a Social Security

disability benefit which exceeds their net income. A skillful writer could probably both make more money and have more fun writing a best seller-comedy of errors based upon what has happened in our industry, than he would have by taking a disability retirement.

MR. ORENSHEIN: At Beneficial Standard Life, we wrote non-can only for a short period from 1965 to about 1970. We have since decided this is not the way to go. We now write policies whereby we can raise rates for an entire state, or, if the regulators decide not to give us the rate increase, we can cancel coverage in that state. There are states which are exceptions - I believe Georgia is one - where you would have to refund 75% of the premiums, less claims, to an individual.

Another point which may be of interest to you is that according to John Montgomery, on California business you may raise rates and merely file the rate increase without waiting for approval, because the California Insurance Department apparently does not have the right to disapprove the rate increases. That speeds up the process somewhat in what has become a problem state.

The third item that I wanted to touch on is an idea that just struck me a few minutes ago. Perhaps the type of renewal provision that would make the most sense would be a policy that was renewable at the option of the company for the first year, guaranteed renewable from perhaps the second through the tenth year, and then non-cancellable thereafter. It would give you a chance to eliminate the overinsured and bad risk in the first year, retain the option of increasing premiums in the next nine years, and thereafter give the insured the type of guarantee that I guess he would like to have from the start.

MR. INGRAHAM: I have some questions with regard to disability buy-out plans. Bill Taylor, why doesn't your company write this coverage? John Angle, why does your company write this coverage, how much do you reinsure, and what has been your claim experience?

MR. TAYLOR: We don't write this coverage because we get a little nervous about the total amount of disability income payable on any one disability.

MR. ANGLE: We write the disability buy-out because so far it has been successful for us. To explain it very briefly, a disability buy-out is a commercial disability policy with a one year elimination period under which the monthly payments during the second year of disability can reach as much as an aggregate of $250,000. Its purpose is that of funding a buy-out agreement which has been negotiated between partners or principal owners of a closely held corporation.

The financial underwriting is tight, and there is still a need to review cases in three to five year intervals to make certain that the purpose still exists. So far the experience has been favorable and we have been able to find reinsurance for the amounts of recoveries that we do not want.

The buy-out is not issued by itself. It is issued in conjunction with a program of other disability insurance sales.

MR. RICHARD L. BERGSTROM: I have a question of a somewhat different nature. About three years ago, Mutual of Omaha jumped into the cash value disability

field; that's where the premiums are refunded at age 65, less any benefits paid. Now we are experiencing two situations we hadn't prepared for. First, individuals who have had early claims are dropping the policy upon recovery. Usually, after receiving several thousand dollars of benefits, they terminate the policy because they don't feel that it is worth it to keep it. The second situation that we have experienced is that the lapse rate assumption in the plan is too high, because the individuals not becoming disabled are going to persist quite a bit longer. So we may end up catching this on both ends; that is, a massive refunding later on in addition to the high early claims. My question is, has anybody else had any experience along this line?

MR. MCCROSSAN: At Canada Life we do have a return of premium option. I might mention a few things regarding this type of plan. First of all, issuing a separate policy and rider can be a serious problem if you have the type of benefit that I think Mr. Bergstrom was describing.

If you pay off only once, at age 65, then it's obviously in the individual's interest to drop it once he has had a claim. Our particular policy got around this provision by having a rolling period of refund, where in effect the first refund is normally after ten years, but upon termination of a claim you immediately start a new 10-year period. Thus, there should be no tendency to lapse this benefit.

His conjecture about the persistency being much better on this business is correct. Lapses are substantially lighter than on regular health business. The trick is to design the basic policy and the rider so that they are reasonably immune to variations in persistency. We sell a very heavy proportion of our business in Canada with this rider. It does solve the replacement situation because we are not obliged to provide cash values upon lapse. Thus, the potential savings element available to the policyholder inhibits him from moving to another company from time-to-time when they have better rates than us.

MR. TAYLOR: Frank Bush talked about Society statistics awhile ago. I would like to make an additional comment on the subject - that is, perhaps we are not collecting all of the right data for a problem such as this. Too often we structure things the way they were years ago. In this area, I think we look at our experience as though the subject policy was the only one that was available. For instance, the LTD experience gives us morbidity results by the amount of disability income coming from the LTD alone. It doesn't tell us how much additional disability income those insureds have, and that amount can be significant. I think that if we are going to talk about demonstrating the extra morbidity that comes from overinsurance, we have to be able to measure that overinsurance.

Similarly, we claim that morbidity varies by elimination period, but I question that we really know that. I think it varies by the period of self-insurance up front on the part of the insured. If you issue a policy with a 180-day elimination period to integrate with a 26-week benefit group coverage having a 7-day wait, I think we should expect to have the same kind of morbidity on that 180-day wait coverage as we would have on coverage that actually has a 7-day wait.