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EFFECTS OF CONSUMERISM & REGULATION ON THE HEALTH INSURANCE INDUSTRY IN CANADA AND THE UNITED STATES

Moderator: RAYMOND L. WHALEY. Panelists: WILLIS W. BURGESS, JR., D. WAYNE CARSTENS, LEAR P. WOOD

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MR. RAYMOND L. WHALEY: We live in contradictory times, in which our society is constantly being subjected to conflicting pressures and stresses, and the established way of doing things seems to be subject to continual challenge. Many of us might deplore the unsettling and disruptive nature of these pressures, and the problems that arise in dealing with them. I would suggest on the contrary that they are both inherent and desirable in a free, dynamic, democratic society and that, not only ought we to accept and welcome them, but we ought to contribute to them ourselves. We ought to treat changes and challenges not as problems but as opportunities.

In recent years, we have witnessed the emergence of two rather strong movements which are not often thought of as being incompatible, but in many respects they are. One is consumerism which, to the extent that it relies on government regulation and enforcement to achieve its ends, inevitably increases taxes and the costs of goods and services. The other movement, which we might dub the "Spirit of Proposition 13", is the demand for lower taxes, less government regulation, zero-base budgeting, "Sunset Laws" and so on.

During our lifetimes, insurance has been very highly regulated in the United States and to a somewhat lesser extent in Canada. In recent years, the forces of consumerism have been quite active in insurance matters. However, the opposing forces of laissez-faire and deregulation have been virtually non-existent. Consequently I think that on the whole the trend in insurance in North America is still very much in the direction of increased regulation.

Some of the demands of consumer activists are, I think, clearly ill-founded, unreasonable or impractical and these types of demands ought to be resisted. But not all consumer ideas fall into these categories by any means. A wise industry will be perceptive and responsive to the reasonable demands of the marketplace. An imperceptive and unresponsive industry invites government intervention. In an industry as highly regulated as insurance even changes which are clearly desirable often require enabling legislation before they can even be implemented voluntarily. But we are also seeing instances of changes which the industry may oppose for very good reasons, being mandated because consumer and human rights activists have simply been more persuasive than others that their demands represent the best interests of society.

MR. D. WAYNE CARSTENS: Lincoln National is right now mainly in the Individual Disability Income business. That's the line of business that I work in and we have closed off our Direct Individual Medical Expense line at the beginning of this year.

We are in the process of filing an entire new portfolio. In one of these products we are attempting to have dollar for dollar offsets for Social Insurance Benefits. Another aspect of this product is to have it on a renewable term type basis. So it would have been interesting to discuss the results of our filing and problems we would run into. Unfortunately all things that are done with committees take longer than you think they will and we are not quite ready to file them. Maybe next year I will have an opportunity to discuss that with you.

As I said before I speak mainly from the point of view of an insurer handling an Individual Disability Income line. We have a large block of medical expense business and we service our group line by providing a group conversion product. This is the perspective from which I speak.

In today's session I would like to briefly touch on at least all the topics which were outlined in the program. I hope that I will not overlap what Will has to say too much, I did have an opportunity to look at his remarks and I think we do cover some different territory. One of the problems in participating in any discussion about the effects of consumerism is to try and avoid turning it into a complaint session or a "misery loves company" scenario. I think we all have a tendacy to do that. Consumerism is here to stay and Regulation continues to closely influence our business. I do think though that, with respect to the insurance industry, the depth and

and intensity of both of these forces has sharpened in recent years. With that influence must come a rededication on all of our parts to make our products from a consumer's point of view as broad based and as equitable as possible. I know that today's session is not devoted to influencing the course of consumerism or regulation but it remains incumbent on each of us to actively participate in that process through our trade organizations and our company representatives in our domiciled states. If we do not take an active role in providing technical and expert advice during the formulation of regulations or in trying to cope with consumerism then I think we must bear the consequences in silence.

The initial topic for today has to do with non-discrimination regulation and legislation. As I said, we are now in the process of filing a new portfolio and one of our products is designed to be used in the professional marketplace. In an effort to react to consumerism we no longer have normal pregnancy as an exception to coverage. We have for some time, covered complications of pregnancy but we now provide and have priced for a full pregnancy coverage benefit. We feel that in the professional marketplace the risk exposure will be reasonable in relation to the coverage sold and that we hope we have adequately priced for the anticipated level of benefit.

Another thing we have done as a reaction to non-discrimination legislation and actions is to create an elimination rider in which we are able to vary the waiting period, benefit period and even benefit amount for certain defined conditions. This will allow us to write coverage where we might not have been able to had we been restricted to full elimination riders or rating systems. I am sure this is not new to some of you but represents a major departure from our former underwriting stance. It will make it incumbent upon us to be better amd more innovative underwriters. The sale of Disability Income carries with it a responsibility on our part to underwrite on a sound basis but also with imagination and recognition of the realities of the marketplace. We must deal with professionals in a professional manner, trying to anticipate their needs by underwriting their lifestyle and pricing for the expected morbidity for these individuals relative to the type of benefits we offer within our policies.

Another key issue still on the horizon with respect to nondiscrimination is the treatment of dual income families and the underwriting of Disability Income insurance. This is becoming a much more prevelant way of life in today's economy and it will impact on our underwriting results in the future. We must recognize that the financial risk in this situation differs from the normal one income family situation and we must deal with it accordingly. However, we must deal with it without discriminating against individuals because of marital status. This will mean that we must allow flexibility in the policy to be able to deal with incomes that change after divorce or death of the spouse. We must be able to deal with single individuals that subsequently marry. It has been my experience that few companies right now are adequately dealing with the situation in their current underwriting rules. We hope to develop some rules and are most grateful to Jerry Parker of the Guardian for his recent work done in connection with Social Security benefits. The results of this work demonstrate dramatically the effect of dual incomes in all types of situations where the insured's income represents varying percentages of the family income. Dealing with dual income families through underwriting rules will further complicate the underwriting process both from the agent's and home office underwriter's

point of view and will force us to further sophisticate our underwriting abilities and knowledge. It will also force us to be more reactive to a changing environment in underwriting disability income insurance.

I'm forced to stay in the professional marketplace again for the next comment although we all recognize that female participation in business is prevalent in all occupational rating classes. In the professional market, in particular, females are taking on higher level positions and a much more active role in the professions. We naturally try to deal with this situation by offering a full range of policy forms to them and, by creating female rates which are non-discriminatory and are based on sound actuarial principles and data and by providing underwriting limits that reflect the income levels of females. Input we have received from our field force and general information that we have available suggests that we should allow a lower income limit for females on the business executive category to which we sell our professional policy. We have resisted this because we feel this is discriminatory. However, we may come to the point where we are forced as an industry to deal with the reality of lagging salaries. Whether this is a recognition of reality or discrimination is a very fine line in today's environment.

The next topic on today's agenda has to do with how companies are dealing with the proliferation of laws and requirements. Historically, the line actuary for individual health in our company has had the responsibility for reviewing laws and regulations and reacting to them. As those of you who work actively in this area know, this has become almost a full time job in recent years. Therefore, about a year ago we created a special position called health compliance consultant who's job it is to deal with laws and regulations, react to them, and deal with the states and the trade associations in either shaping the regulations or complying with them. This individual has become a key member of our team when it comes to policy drafting, rate revision filing or initial rate filing in that he has the knowledge and background to be able to assure that our initial filing meets the current standards on a state by state basis and that he is able to react to the changing regulatory stances as they occur. This is particularly important in a rate increase environment and especially for closed blocks of business where medical cost inflation is producing impacts upon rates which make biannual and even annual rate increases a necessity. Rate increases must be filed and approved as quickly as possible. This makes it very important that an individual have full responsibility for the approval process because of the great impact that he can have upon our underwriting results. Another key role for this individual is to recognize and input line management data processing needs and supports that reflect the regulator's changing requests for information and experience updates. I cannot overemphasize the importance of having such an individual within your company whose prime responsibility is in this area and if any of you already have such a job I both empathize with the problems and frustrations and thank you for taking on a task such as this.

The third topic, "significant new or pending legislation and regulation together with trends," is one that I am sure will produce a different list for different companies and different people depending on product line, geographical environment, level of sophistication of products and other factors. I will, therefore, try to touch upon some of the major new items that I see impacting on us and hopefully on you on a wider ranging basis.

We have already covered one aspect of this topic, non-discrimination legislation and regulation. Another recent trend and one that will surely continue is the subject of readability and simplified language. At the present time there is an NAIC model for readability and at least half a dozen states are in some stage of implementing guidelines for simplified language. One would be wise in revamping a portfolio or reviewing in force policy forms to consider simplifying the language. There is already available simplified language for the uniform policy provisions. I had an opportunity to talk with one actuary recently who has redone several policy forms and,in my mind,achieved an unbelievable FLESCH test score of 55. He indicated to me that it took several months to draft the policy forms which are by the way, very innovative, and it took another year to get it into simplified language. It is a task that no one will be able to take on easily. Unfortuantely the simplification process usually involves dropping out many of the contractual terms and phrases which help to clarify the claims process since they usually represent the most complicated language in the policy. Readability is here to stay and should be dealt with accordingly. The regulatory process must quickly establish reasonably uniform language that encompasses certain basic definitions in the policy and have that language tested in court cases and insurance department proceedings. It will be only after this process is through that we will be able to provide the consumer with a product that both of us can comfortably live with.

Another recent trend which may not appeal to such a wide range of people as is in this audience is the trend toward minimum standards for group conversion policies. These standards in our opinion, also influence the conversions which should be allowed on individual policies for children attaining the limiting age of the policy or spouses in a divorce situation. Minimum standards for group conversions are creating policy forms which are very comprehensive in nature and should eventually have some impact upon our underwriting results if we do not deal adequately with the premium structure to support them. That is, we are issuing very high benefit comprehensive policies to individuals on a guaranteed issue basis. One of our major protections in the past in group conversion policies was the limited benefit structure, inside limits and high premiums we were able to charge. We are now being required to offer policies which are similar or better than our former ratebook policies and with premiums that are heavily controlled. The results must be studied carefully and we have to react to adverse trends if they develop. As I indicated, I think an impact here is on our individual conversions also. It has been our philosophy that an individual converting from an individual policy should be given a group conversion policy. This philosophy was forced on us when we recently closed our individual medical expense business to direct sales. In states where we were forced to issue a comprehensive group conversion policy, we have issued individuals the same coverage out of an individual policy. Unfortunately I think on the horizon is regulation and legislation which will also tend to deal with individual conversions particularly as companies have a tendancy to close off lines of business or policy forms are done away with.

A more wide-ranging trend that impacted upon us has been the regulation with respect to loss ratios. A committee of which Will Burgess is a member is giving technical advice to the NAIC as to minimum loss ratio standards. Joe Farr has written an excellent paper about loss ratios, which is the

subject of one of the sessions at this meeting. It does an excellent job of analysing ratios and explaining the different technicalities involved in them. The whole topic of minimum loss ratios demands close attention and scrutiny by actuaries. The mere definition of loss ratio is subject to several interpretations. It is also incumbent upon to us to identify mitigating circumstances and influencing factors which must be taken into consideration by the regulators in drafting minimum loss ratios and dealing with loss ratio results.

Lastly, I'd like to touch briefly on the subject of minimum standards for health insurance policies. As I indicated to you, we recently closed off our Direct Individual Medical Expense line. One of the chief influencing factors in this decision was the promulgation of minimum standards for medical expense policies. These minimum standards call for a policy form which we feel, in many instances, provides benefits which are uninsurable. This includes mental health benefits, extensive out-patient benefits, and other benefits over which, in an environment where we already have very little control over medical costs, we have even less control. The minimum standards for disability income fortunately are not nearly as cumbersome.

The next topic is one where each one of us could come to the podium and spend anywhere from several minutes to several hours expounding upon the problems we are having with various state insurance departments.

Rate increases have been one of my chief concerns in recent months. We recently filed rate increases on two of our largest blocks of medical expense policies and are about to file a large rate increase on our largest block of non-cancellable disability income policies. Our success in getting rate increases approved has been reasonable. However, our largest concentration of business is in Florida where we continue to have problems with rate increases and I am sure many of you can empathize. Our primary problem seems to be the fact that the Florida department is now requiring that we produce Florida based data on these two policy forms. Some of you may be in the same position we are, in that our sophistication in producing statistics on this basis is somewhat limited. We are, by comparison, a small line of business within our company. We therefore, have not had the type of data processing support that allows us to produce information to this depth and breadth on a very quick turnaround basis. However, with the large amount of business involved and the size of the rate increase we are going after we are going to try to develop some kind of paid loss ratios for the Florida department. My only concern is what other type of objections they will then raise with respect to this rate increase. The most interesting thing about rate increases is the unpredictability about how a state will react to a rate increase. We have always been in the position of allowing our experience to deteriorate to the point where when we request a rate increase it is usually a large one. We then begin a cycle of requesting increases on an every other year basis. We resist requesting that initial rate increase until the results are sufficiently poor so that the trend is firmly established and we have achieved an overall loss ratio which reflects prior favourable experience as well as recent poor experience. We then extrapolate the recent poor experience so as to judge the level of rate increase which will bring future results to a more normal level.

As I indicated previously one of the responsibilities of our compliance specialist is to maintain an accurate file that enables us to comply with specific contract wordings required on a state by state basis. I am sure each of you has a complete file of policy forms which must be varied on a state by state basis. Unfortunately, the examples of variations in contract language are too numerous to get into in a meeting like this. Suffice it to say that certain states have language requirements which must be complied with to the letter before policy forms will be approved. It behooves us to know these variations and to deal with them accordingly, particularly as we try to simplify the language in our policy.

As I also indicated previously we try to keep abreast of the latest positions various states are taking with respect to policy filings so that we can anticipate and effectively deal with requirements in our original filing. We do not try to file a general policy form and then deal with the variations the state is asking for.

I hope that this brief walkthrough of the compliance environment has helped bring things into perspective. With respect to this topic, we live in a complicated, ever-changing world and one in which we must be able to react quickly. We must do this within the framework of each of our companies and the personnel and time available. We must also do it by purposefully working with our trade associations and state regulators. Relationships must be established and strengthened and we must lend our expertise when and where it is needed. It is only through actions such as these that we will assure ourselves of being called upon to input into the regulatory process and thereby enable ourselves to anticipate change and flow with it. With respect to the consumer movement, we need to keep ourselves informed and anticipatory and we need to adequately deal with those topics and causes which have legitimate bases in the insurance world and insurance principles. At the same time we need to knowledgeably and honestly combat those causes and trends which wreck the insuring principle. It is only by honestly exposing our industry to the consumer's review and by educating the consumer as to the basic insurance principles that we will assure that the consumer movement deals with us on a fair basis.

MR. WHALEY: I'm sure Mr. Carstens' comments may have raised some questions but I think our format will be that we will go through all of the speakers and then throw the whole subject open to question. So we will now call on Will Burgess to give us his comments.

MR. WILLIS W. BURGESS, JR.: I have a couple of general comments before I get into some specifics on the problems we are facing in the consumer and the regulatory area.

First of all, as Wayne pointed out, we are faced with challenges with which I personally believe we have never been faced before in the history of health insurance. I think that the series of challenges that we have facing us now is very formidable.

If the tone of my speech seems negative it is not intended to be. I believe that we can meet the challenge but I think in order to solve any problem the very first thing you have to do is to define the problem and this is what I am going to try to do today by providing an overview of the type of challenge with which we are being faced in the health insurance industry.

The second point I would like to make is that I'm with the largest writer of Individual Hospital Meidcal and Expense business and we have no intention of getting out of the market. We hope to meet the challenge - we have done it before and we've got our work cut out for us, but we intend to stay in that market.

Now I'll get into the impact of non-discrimination legislation and regulations. The legislative and regulatory climate for the selection and classification of insurance risks has changed significantly. In the past, companies were generally prohibited from unfair discrimination between individuals of the same class, in the premiums charged or benefits provided, but this did not relate to favoring one class over another. Equity rather than equality has been used in the selection of classification of risks.

The climate has changed, as illustrated by current developments.

1. Current Developments of Interest

A model regulation had been adopted by the NAIC dealing with unfair discrimination on the basis of blindness or partial blindness. Discrimination in coverage or premiums is prohibited unless based on "sound actuarial principles or is related to actual or reasonably anticipated experience." The NAIC Task Force to Investigate Discrimination Because of Handicap, Physical or Mental Conditions recommended extending the regulation to any impairment. At the NAIC meeting earlier this week the subcommittee to which the task force reported unanimously agreed that that regulation would be extended to any impairment and I imagine that the full NAIC will approve that recommendation today. (N.B. The NAIC committee has adopted this recommendation.)

The Pregnancy Disability Bill was enacted in 1978, prohibiting discriminatory employment practices for pregnant women and requiring that fringe benefit plans treat pregnancy the same as any other condition in the case of employee coverage.

The current NAIC Task Force on Sex Discrimination is involved with "the review of rating systems ... currently in use in an attempt to determine the validity of assumptions, statistics, and actuarial methods which have been routinely accepted in the past." At its December 1978 meeting the NAIC approved the recommendation by the task force that called on the insurance industry to provide "information explaining the differences between their data on disability and health insurance for women, and the data shown in non-industry studies" and that the task force "consider Federal and State legislative initiatives, the transcript of the Nov. 13, 1978 public hearing, and the data provided by industry, government, and consumers, in proposing amendments to current NAIC Model Laws and Regulations." In response to this request by the task force to the insurance industry for such information, the HIAA and ACLI presented a joint 47 page statement before the task force on April 9, 1979. It is my understanding that the task force is reviewing this report, and will respond in writing and report to the NAIC in December 1979.

In December 1978 the NAIC Automobile Insurance Rates and Rating Procedures Task Force recommended amendments of NAIC model bills, acts and regulations so as to prohibit classification and underwriting by sex and marital status, to "require stricter statistical standards for the evaluation of

classification systems," to further study and evaluate age as a rating factor, to implement these amended regulations at the state level as quickly as possible, and to develop regulatory standards and guidelines for evaluation of rates and rate differentials. The NAIC is considering this action. At the NAIC meeting of the subcommittee to which this task force reports, there was a marathon 9-hour session at which the subcommittee voted by a 6-2 vote to adopt the recommendation of the task force and I understand the full NAIC will be voting on this proposal today. (N.B. The NAIC adopted this regulation.)

States in which age, sex, and marital status have been abandoned as rating classifications for automobile insurance or are being considered for such action include Hawaii, North Carolina, Louisiana, Massachusetts, Florida, Michigan, Wisconsin and New York.

The Senate Judiciary Committee on Citizens' and Shareholders' Rights has been investigating "whether the use of such categories as age, sex, race, neighbourhood, occupation and marital status -- based on personal characteristics that consumers cannot control -- is fair."

In 1977 a Michigan Law went into effect which enumerates "Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance." Included among these are:

. Refusing to insure, or refusing to continue to insure, or limiting the the amount of coverage available to an individual or risk because of:

  (a) Race, colour, creed, marital status, sex or national origin, except that marital status may be used to classify individuals or risks for the purpose of insuring family units.

  (b) The residence, age, handicap or occupation of the individual or the location of the risk, unless there is a reasonable relationship between such factor and the extent of the risk or coverage.

. Sharing a different rate for the same coverage based on sex, marital status, age, residence, location of risk, handicap or occupation unless the rate differential is based on sound actuarial principles, a reasonable classification system and is related to the actual and credible loss statistics or reasonably anticipated experience in the case of new coverages.

The Michigan Insurance Bureau prepared a recent draft of rules to cover this legislation and met with an advisory committee last month. Some of the observations on the draft were:

. It would be deemed unfair for a company to have a significantly lower percent of risks in force than are found in the general population for such categories as race, colour, creed, marital status, sex, residence, age, handicap, occupation, etc.

. It appears to threaten an insurer's ability to establish reasonable rating and underwriting classifications.

. It might require a company to provide anticipated loss ratios for each rate cell for each plan it has.

Where is this leading? The battle lines have been forming. On the one side, insurance companies trying to preserve traditional risk classification systems. On the other, consumerists and regulators opposed to classification and not really interested in facts statistically justifying risk classification systems but in social acceptability and political considerations. In the middle, insurance companies and regulators trying to reach acceptable compromises, and the various segments of the insured and insuring public around whom the controversy rages. It's one of the greatest challenges the insurance industry has ever faced. For the health insurance industry, there is the distinct possibility that risk classification based on sex or physical condition will end. If so, this will mean that significant segments of the insuring public will have to pay higher premiums to subsidize the beneficiaries of such a change. There are no free lunches, and there are no free insurance benefits to society.

2. How are companies dealing with the proliferation of various laws and requirements?

The proliferation of laws and requirements is of course greatly compounded by the individual differences in these laws and requirements among the 50 states. For this reason, many companies become involved with the NAIC machinery attempting to obtain uniformity in various laws and requirements through model bills, acts and regulations. They will follow laws and requirements in which they are particularly interested through the NAIC machinery and, when it appears to be the most effective course of action, attend meetings of NAIC task forces, subcommittees and committees and their advisory committees, and prepare written and/or oral statements. The HIAA is of course very much involved in these activities as it pertains to health insurance. Member companies are kept informed of developments, and many are directly involved through participation in HIAA committees and subcommittees.

Occasionally a particular state will propose or adopt a law or regulation in which a company is particularly interested. If it is an HIAA member, it will follow the activity through HIAA contracts. Occasionally, it will take a personal interest and deal directly with that state in following the course of action for the law and requirement. If there is enough at stake and careful consideration leaves no other viable alternative, it may be necessary in rare circumstances for an insurer to use legal manoeuvres to attempt to resolve the matter satisfactorily.

The Federal government has been taking an increasing interest in the health insurance business. As a result, many companies are establishing a Washington, D.C. office and/or hiring Washington counsel.

The proliferation of laws and requirements has increased the expenses involved in analyzing, acting upon and administering such laws and requirements. Many companies now have government relations areas which specialize in such matters, and more and more time is also being spent on matters directly or indirectly tied to them by areas responsible for preparing, filing, pricing, selling and administering health insurance forms. The cost, of course, is passed on to the consumer, unless restricted directly or indirectly through these proliferating laws and requirements.

3. Summary of significant new or pending developments

Confronting the health insurance industry are such issues as: the extent to which Federal anti-trust laws would apply; whether the insurance business should be regulated by the states, the Federal government, or both; the spectre of national health insurance and the form it would take; and the steps to be taken by private insurers and by the Federal government to provide needed but sound disability income programs. Some of the developments in these areas are:

. Federal Regulation - Numerous bills have been introduced which in various ways would amend or repeal the McCarran-Ferguson Act. Another bill calls for a study to be made by the FTC to determine whether life and health insurance policy forms should require the approval of HEW.

. National Health Insurance - The proposals which have received the most interest since the 96th Congress convened in January are those proposed by Senator Long, President Carter, HIAA and Senator Kennedy. These have been treated in another concurrent session of this meeting so I am not going to deal with them.

. Social Security Disability Income Program - This program has three major problems: excessive replacement ratios for those with dependents; cumbersome and ineffective claim administration not under adequate control; and lack of effort to identify claimants who should recover.

Major recommendations of the HIAA and ACLI to improve the program include:

(a) Experiments in substantial gainful activity designed to motivate trial work with appropriate reductions in benefits during periods of trial work.

(b) Reducing maximum family benefits and replacement ratios.

(c) Modifying claim administration, including the issues of whether the present definition is reasonable and sound, whether benefit costs are too high and whether sufficient efforts are being made to rehabilitate disabled beneficiaries.

The House Ways & Means Committee approved HR 3236, which would take a step toward reducing excessive replacement ratios, by placing a cap of 80% of the worker's average indexed monthly earnings (AIME) or 150% of the worker's primary insurance amount (PIA), if lower. However, the Committee by a narrow vote defeated an amendment that would have established a stricter maximum disability family benefit of 80% of the AIME or 130% of the PIA, if lower. It is expected that the amendment will be voted upon by the full House when it reaches the floor.

. Guidelines for the Filing of Rates for Individual Health and for the Reasonableness of Premiums in Relation to Benefits - For almost 2 years, an NAIC task force and an HIAA subcommittee have been working on these guidelines.

The salient features of the latest draft of the Guidelines are:

General - Contains guidelines as to when rate filing is required, the general contents of all rate filings, the material to be included for

filing of rate revisions, experience records to be maintained and some of the relevant factors to be considered in determining the credibility and appropriateness of experience data.

Reasonableness of Premiums in Relation to Benefits - Contains minimum anticipated loss ratio standards over the entire period for which rates are computed to provide coverage, for new forms and rate revisions. These are graded by average annual premium, type of coverage and renewability. As an example, the minimum anticipated loss ratio standard for a GR policy with an average annual premium of $200 or more would be 55% for a Medical Expense policy and 50% for other types.

Anticipated loss ratios lower than the minimum require justification.

4. Problems companies are having with various insurance departments.

As I mentioned, my company is a large writer of hospital, medical and surgical expense coverage, and my comments will be confined to our experience with these types of benefits.

. General comments on contract wording and approval of policy filings - Policy filings approvals can be divided into three categories. Some states will occasionally raise an objection to which a reasonable approach can generally be taken to comply with the applicable laws and regulations. We find 22 states in this category.

Ten states pose real challenges in attempting to comply with their laws and regulations. Products are frequently submitted in draft, in anticipation of objections.

Other states do not fit either of these categories. A given state may approve one product without comment, have modest comments on another and extensive comments on another. Each case presents a separate challenge, some of which can be met reasonably and others presenting more difficulty.

Many of the laws are difficult to interpret because they were written by people who were not knowledgeable in insurance matters. Consequently, the resultant regulations are often ambiguous. Insurance departments also make some administrative decisions which have no basis in law. This makes it very challenging to obtain policy approvals.

It is getting more difficult to standardize filings from state to state, because of the differences in state laws, regulations and the individual interpretations and requirements of the Insurance Department personnel involved.

. Readability - At its June 1978 meeting, the NAIC adopted the Model Life and Health Insurance Policy Simplification Act which applies to life insurance, health insurance, and credit insurance and which requires a score of 40 on the FLESCH test. Many states are expected to pass readability bills in 1979.

. Mandated Benefits - Some examples of various mandated benefits are:

(a) Alcoholism, drug dependency and mental illness. - Minnesota requires that coverage be offered for losses due to alcoholism, chemical

dependency and drug addiction in group and individual health policies issued or renewed in Minnesota. This applies to hospital expense, hospital indemnity, medical-surgical, Medicare supplement and dread disease policies. Regular policy benefits must be provided, subject to prescribed limits.

Colorado requires that if a policy provides benefits for mental illness, the policy cannot deny benefits when mental illness is treated by a state institution. A company thus has the choice of excluding mental illness or, when providing mental illness, including coverage in a state institution. Virginia requires that all individual and group A&H policies providing coverage on an expense incurred basis shall, in the case of benefits based upon treatment of an inpatient in a mental hospital or general hospital, provide coverage for mental, emotional, or nervous disorders, alcoholism or drug addiction which may be limited to 30 days of active treatment in any policy year.

(b) Maternity Coverage. - New York requires that regular policy benefits be required for maternity as a hospital-medical-surgical expense. Maryland requires that if hospital benefits are provided for normal pregnancy, payment shall be to the same extent as for any other covered illness. For hospital, medical and surgical expense policies which don't cover maternity, a mandatory maternity benefit adds a sizeable amount to the premium, especially if confined to the female child-bearing ages. A company has to decide over what segment of the insuring population to spread the premium for the additional benefit costs in order to minimize anti-selection and keep the policy attractive to as large a segment of the insuring population as possible.

Requirements such as these pose a serious challenge to a company in offering policies containing such mandated maternity benefits. Careful consideration would be given as to whether the policies would be offered.

(c) Second Surgical Opinion. - New York requires benefits for a second surgical opinion within the following guidelines: For surgical beneifts based on a relative value schedule, a fixed value of 3-7 units should be assigned to the 2nd surgical opinion; For surgical benefits pursuant to a dollar schedule, a fixed value of 5-10% of the maximum amount payable for any surgical procedure should be assigned to the 2nd surgical opinion.

(d) General Considerations for Mandated Benefits - We review mandated benefits on a state by state, plan by plan basis to determine the risk of providing the revised coverage with mandated benefits and the optimum premium to be charged.

. Medicare Supplement Insurance - At its December 1978 meeting the NAIC adopted amendments to the NAIC Individual Accident & Sickness Act to provide for minimum benefit standards and disclosure requirements for Medicare supplement insurance. Since that time the NAIC Medicare Task Force, its advisory committee and the HIAA Task Force on Medicare Supplement Policies, have been involved with a model Buyer's Guide

for Medicare supplemental insurance, and proposed changes regarding Medicare Supplement Insurance to the NAIC Model Regulation to implement the Individual Accident and Sickness Insurance Minimum Standards Act, including a loss ratio benchmark section.

The FTC also plans to work with HEW and the states on minimum standards for Medicare supplement policies and a basis for comparing the prices and values of such policies.

Several bills have been proposed in Congress regarding Medicare supplement insurance. Among these is one proposed by Representative Pepper which would direct HEW to certify Medicare supplement policies, establish minimum standards for such policies and require a 75% loss ratio "by the end of the second calendar year in which such policy is in effect." Senator Chiles proposed a bill to provide minimum standards for Medicare Supplement insurance to be recommended to the states for action and FTC study.

Many states have requirements of minimum standards, disclosure rules, text language, mandated benefits, and/or outlines of coverage. This requires several policy forms, disclosure forms and outlines of coverage.

Several states require automatic escalation in benefits with increases in the Medicare deductibles, but do not permit corresponding automatic escalation in rates.

As I said before, I honestly feel we are faced with the greatest series of challenges that we have ever been faced with but our work is cut out for us and I think that if we roll up our sleeves and go to work, between the regulators, the consumerists and the insurance companies and the actuaries representing all three views, I think we can solve these problems.

MR. WHALEY: As I mentioned in my opening remarks, insurance is somewhat less regulated in Canada than in the U.S. and at least in life and A&S lines we're not confronted with the policy filing and rate filing problems that companies in the U.S. are faced with. Neverthless we do have both Federal and Provincial Insurance Departments and we do have human rights legislation in most of our provinces and we do have an active Consumers Association of Canada which has been in some sense a thorn in the side of the insurance companies.

I felt it would be useful to have someone from the other side of the fence, so to speak, participate in our panel and we are happy to have Lear Wood who is Deputy Superintendent of Insurance in the Province of Ontario. Lear is going to speak generally from the point of view of the regulator and on some of the questions on the agenda from the Canadian point of view.

MR. LEAR P. WOOD: My views are shaped by my association with most of the government insurance regulators in Canada and I am sure that all of them would join me in welcoming you to this meeting here in Banff, expecially those of you from south of the border. In my talk I will refer to Ontario but when I refer to Ontario I think the points that I raise, the ideas that I try to suggest, would be acceptable to most of the other superintendents of insurance in Canada. I do not intend to follow the topic in the form

in which the others have. I am going to concentrate on topic #6 and make passing reference to the other topics as I go along.

Topic #6 probably contemplates that the regulator is an elected government official or a civil servant. We do not believe that the responsibility of regulation of insurance should be restricted to government persons. It should also be the responsibility of the industry, the press and even the consumer himself. All have their roles to play in regulating the insurance business and I hope that my remarks will emphasize this view.

Our former Minister of Consumer and Commerical Relations said last year "we are getting out of the business of regulating certain functions and having regulatory bodies which are not necessary."

The result is that deregulation has become a policy of the Ontario government and active steps have already been taken to implement this policy in the field of insurance.

Mr. Alex Flam, Senior Vice-President, Union Carbide Corporation said to the commercial development association in New York last year that: "...business has a checkered history and we continue to labour under a legacy of mistrust. That mistrust, I believe, is the most serious obstacle in the way of reducing the burden of regulation. The fact is, that few are willing to believe business can be counted on to do what is right.....unless pressured to do so. Surveys continue to show that most Americans believe that business puts profits ahead of morality. They feel business cares little about the consumer. That we care little about the environment. In sum, says one research group, most Americans feel that business needs more watching over."

Our deregulation policy which we have started to put into place, seems to fly in the face of this sentiment if the sentiment is applicable to the insurance industry. This view must be changed or we may fail in our efforts. If we fail and it becomes necessary to revert back to further escalation of government regulation, a critical situation will be created in Canada where government social insurance programs are already extensive.

In Ontario we are in the process of deregulation of some aspects of government involvement in the licensing of agents and adjusters. To counter-balance this we shall attempt to place more responsibility on the insurers who use the services of agents and adjusters.

In the field of A&S insurance we are asking the industry to undertake a more active part in the regulation of advertising practices. This latter item is a problem area in Canada and qualifies as a candidate under topic #4.

With the broadened definition of who are or who should be the regulators let me now turn to the role of the regulator.

Again I am going to quote from a speech given by our former Minister as follows: "In the '80s, I think we can look for a more specific, self-help approach to consumerism. This must manifest itself in more aggressive fact finding: more effective complaining by individual consumers to business directly and more effective use of the news media to pressure and embarrass companies which fail to act responsibly. In short, I think consumers must enter an era of selective protest, aimed at ever changing short-term goals.

Institutions like the Consumers Association of Canada, governments, industry associations and consumer education programs will need flexibility, dedication and sheer energy to survive and actually encourage consumers in the new environment.

In other words, consumers will no longer rely on institutions to fight institutions. They don't trust or believe in the institutions approach. People must increasingly depend on, use and mount strong pressures -- both in the courts and in the media -- if they think they aren't getting fair treatment."

If this indeed be the requirements of the '80s, a key role must be the education of the consumer. In addition, the consumer must be provided with the information he needs to assess the industry and what it has to offer. For example, in the field of consumer protection in this country, the consumer has been given information on the interest rate he must pay when he makes a loan. Should he not expect to receive information to enable him to make comparisons when he buys insurance? I think that disclosure of individualized expected claims to premium ratio would help in this regard but I also recognize that consumer education would be required if he is to be expected to use or even understand such information.

Now to make a little change in pace, another role which I think should be actively undertaken by someone is to monitor the total government presence in providing benefits and to make suggestions for its improvement. For example, most people would agree that the overall disability income picture which currently exists in Canada needs to be overhauled.

Potential sources of disability income benefits to Canadians are so multitudinous that one would expect that no one could slip through the tangled net. However, many do and suffer the consequences. The complicated picture includes benefits under the Canada Pension Plan and the Unemployment Insurance Plan, both Federal government plans. There are also benefits available under the various Provincial Workmen's Companesion Plans and No Fault Accident Benefits incorporated into their mandatory automobile policies. In addition, consumers may have entitlement to Disability Income Benefits under their employer pension and/or group plans as well as having purchased private insurance benefits under creditors group insurance,association plans or individual policies.

How are all these benefits integrated? Some are, some are not. Insurers have been prevented in some areas from integrating government benefits, in others, they are free to do so. In some cases, the government insists on being the first payor, in others it wants to be the second payor.

What the Canadian consumer and tax-payer needs is a champion who will help them regulate the system.

I personally feel the industry, with its expertise and obvious self-interest, should create a role for itself in this matter.

In Canada the main burden of solvency regulation is borne by the Federal Superintendent of Insurance since most companies are Federally incorporated and all foreign companies come under its financial surveillance. The role of this office has in recent years been one of developing a more flexible approach to its solvency regulations. It has transferred responsibility to

the companies and the company actuaries and it is attempting to have its financial reporting requirements follow general accounting practices more closely.

The emphasis of the law in Ontario and the other provinces places on the provincial superintendents the responsibility of regulating the types of policies to be sold and the manner in which these are marketed. The licensing of agents, adjusters and insurers is a part of this responsibility.

To carry out our responsibilities we use guidelines whenever possible; we try for uniformity throughout Canada; we avoid rate control and policy filings. The only exception to this last objective was when we were forced to introduce a minimum loss ratio for creditor's group insurance and to require policy filings all at the suggestion of the industry.

Our major effort in recent years has been directed towards providing consumers with meaningful disclosure. For example, we have introduced loss ratio disclosure in individual A&S policies and we have set standards for mass merchandising advertising.

The future includes the development of guidelines pertaining to disclosure of group benefits to certificate holders. Connected to this is a requirement that insurers accept a greater responsibility towards the group lives insured than they have officially done in the past.

Now before closing, I would specifically like to make some comments with regard to topic #1. Our present Minister has asked the automobile industry to find ways and means of eliminating the use of age, sex and marital status in the setting of automobile insurance rates. He has done so because he thinks there are alternatives available to the private automobile industry which are much more acceptable to the public under a compulsory automobile insurance system.

However, I want to take this opportunity to make it clear that Ontario's call for so-called unisex automobile insurance rates is not intended to set a precedent for life and health insurance.

We fully agree with the industry that the elimination of age and sex in the setting of life and health insurance rates would be unfair and would make the continued operation of the life and health insurance business in this country most difficult if not impossible.

The Insurance Act of Ontario outlaws unfair discrimination in the insurance business. Unfortunately, it does not set out a definition of "fair discrimination." This could create problems should acts pertaining to human rights introduce provisions which generally prohibit discrimination of all forms in the marketplace.

It may be, that if conflict is to be avoided, the insurance acts of the provinces of Canada should be made more precise as to what discrimination is to be allowed in the business of insurance. I believe the problem is particularly imminent in Alberta where a number of cases have been looked at.

MR. WHALEY: I don't have the precise details but I will elaborate from memory. Lear has referred to the situation here in the Province of Alberta. My recollection of the facts are that under the Individual's Rights Protection Act it is an offense to discriminate in the furnishing of services to the public on the grounds of race, creed, colour, sex and so on. The word is simply discriminate and it does not say anything about unfair discrimination. Five complaints were brought to the Board; four of them involved young male drivers who complained that they had to pay more for their automobile insurance than females of the same category would and the fifth was a deferred annuity from a life insurance company. It was a lady complaining that she would eventually receive less in annuity benefits than if she were a male of the same age. The Commission of Inquiry examined the cases carefully and heard evidence about the statistical basis used by the automobile insurance companies and the life insurance companies for varying their rates. I think they were impressed by the evidence but nevertheless found that they had no alternative under the Act, which simply made it an offense to discriminate whether it was fair discrimination or unfair discrimination, but to find that there had in fact been an offense committed. At the same time they found that no substantial damages had been done and therefore there were no monetary awards. This has brought the whole matter to a head here in Alberta and the insurance industries are, I believe, attempting to persuade the authorities in Alberta that the Act ought to be amended to permit the insurance companies to differentiate rates by sex or by any other classification where there is demonstrable evidence and statistically valid evidence that different losses would arise. That is an elaboration of the situation here.

We do have a good deal of time this morning for comments and questions from the floor and so we will welcome your thoughts and your response to the discussions that each of the three people here have given.

MR. RALPH H. GOEBEL: My question is for Mr. Carstens. You said something to the effect that you allow a lower income limit for professional classes. I was wondering what that meant.

MR. CARSTENS: We have within our professional policy a special definition of the individuals to whom we will sell this policy. It is a Non-Can residual disability income policy that we are offering only in the professional marketplace. One of the general categories other than the normal lawyer, doctor, dentist type categories is non-owner business executives. We have placed a requirement on that category, and this is prevelant within the industry,of a minimum dollar amount of income. Presently that dollar amount of income is $30,000. There has been a lot of discussion that we should have a lower income level for female business executives. The figure that has been tossed around is $25,000. So far we have resisted doing this but there has been a lot of evidence that maybe we should.

MR. RONALD BECKER: I have two questions fo Mr. Burgess. Your company issues a nursing home policy. How are you reacting to regulations in states like Nebraska and Georgia where coverage is required for intermediate care facilities as opposed to regular skilled nursing homes? Do you see any other areas of coverage where services we formerly didn't insure are now being mandated for insurance?

MR. BURGESS: In the medicare supplement area, about a year ago considerable amount of flack developed over the sale of medicare supplement insurance and abuses in the marketplace. We, like all other companies in the industry, found evidence that some of our agents had abused the sale of medicare supplement insurance to the over-age. We investigated the entire block of this business and we found a very small percentage of abuses. We took action to correct them. At the same time we recognized the problems in this area and we embarked upon a corporate commitment which we call Project Caring. We took a hard look at the entire medicare supplement problem. We developed a new set of underwriting rules that includes a priority of needs. We are adhering rigidly to these rules to make sure these people are not over-insured and that they do get the coverage in the proper priority. One of the areas you mentioned that was causing flack and misunderstanding was the nursing home policy. In essence what we had was a policy designed to supplement the type of nursing home coverage that medicare actually provides. Namely, skilled nursing care. To minimize misunderstanding the policy was broadened to cover custodial, intermediate or skilled nursing care on the same basis.

MR. RICHARD G. RINK: I'd like to illicite possible comment from Mr. Burgess concerning the rating factors used in classification systems. Apparently we are being told or it is being suggested by the consumer's movement that sex and age in certain types of insurance, should not be used as a rating factor. It struck me that there is nothing wrong with any rating factor that is defineable other than the omission of a factor that is very pertinent in getting to the right classification system. It struck me that the thing that they are talking about these days is the elimination of certain rating factors rather than proposing other factors that create unfairness by their omission. Would you care to comment on this?

MR. BURGESS: Well I think from what I gathered at the meeting of the NAIC earlier this week, it seems to me the key issue we have here, in addition of course to attempting to preserve the traditional risk and rate classification systems, is that we are faced with regulations saying eliminate this particular factor. But we haven't really been given time to develop alternative means of solving this problem. There is a feeling within the industry that there are quite a few companies and actuaries that would really like to tackle this problem seriously and get to viable alternatives on some type of a reasonable basis. The strong objection that was raised to the proposed regulation was that we are being told summarily that classification systems that have been used for a long time may no longer be used and we are not given any time to phase in alternatives. I think this is the whole key issue to this problem. I don't know if I have answered your problem but this is how I see the issues involved.

MR. WOOD: The gentleman mentioned all classes of insurance so I will take automobile insurance because it gives you some idea of the problem. Automobile insurance is fairly unique in that we think that there are viable alternatives to the classification let's say, of age. The statistics are clear, at least in my province, that a young person between 16 and 18 experiences a frequency of claims of three times the mature groups. The amount of damage done on average when a young driver is involved in an accident is maybe as much as 50% more. The combinations of these two factors means that using an age classification system the rates for these drivers must be at least three times greater than the average. We talk

about the historic classification systems. In my view they are, to a large extent, subjective. In the young groups there are certainly a large number of excellent drivers and responsible drivers. In fact, there are numbers of drivers who do not drive very much, but in our historic classification system no distinction is made between the mileage driven or any attempt made to identify mileage for young groups, whereas an attempt is made in the mature groups. The system that has built up gives some recognition to claims experience of the individual and to his conviction records but in our view not enough. The worst drivers are grouped together with what we could call the medium class of drivers because, I guess, if the worst drivers were put in a group they could not afford to pay the premiums and the concept of affordability comes in. To summarize, automobile insurance is unique. We believe that there are alternatives: mileage, driving experience, etc. Under a system of compusory insurance, and that's what we have, and I think many of the states and the other provinces have, we must when we bring our young people into the system not necessarily burden them immediately before they demonstrate they are poor drivers with the burden of their irresponsible colleagues. That is why we think the automobile insurance is considerably different than the life and health insurance where age and sex are probably biologically important and certainly in life at some time you have to die -- in automobile insurance you can go through your lifetime without having an accident.

MR. BURGESS: I am happy to hear you say that you feel that automobile insurance is unique because at the NAIC meeting there was a tendancy to equate life and health with automobile insurance in the sex and marital status discussions. The opinion was expressed that while we, the commissioners, are eliminating sex and marital status from automobile why shouldn't we be doing the same thing for health and maybe life. One of the questions that the NAIC task force addressed to the industry is why sex and marital status should not be eliminated in the health insurance business. While what you say is, I think, very pertinent and should be given a lot of consideration as a practical matter, there are a lot of problems we are running into because of the attacks on automobile insurance rate classification.

MR. DONALD M. PETERSON: I think the argument that Johnny shoudn't pay a higher automobile insurance premium because he may not have an accident because he may not drive fast, probably can be extended to the life insurance area. You can have several forty year olds and one of them may not die 27 years from that date as anticipated. I think it is a poor argument to say that that's the reason for unisex or uniage rates in automobile insurance. There are better arguments than that.

MR. JOHN S. ACHESON: A question for Mr. Wood. I shuddered when you spoke of de-regulating licensing and qualification of agents. This is relatively new on the scene and we have heard little about it. I wonder if you are in the position to give us a little more background on it?

MR. WOOD: Unfortunately, I can't. It is in the process of development as you probably well know. Discussions are going on with both the agents' organizations and with the insurance industry in an attempt to find the means whereby we get out of the picture and put more responsibility back with the insurers and the agents. Canada follows the United States by about five or ten years. If we see what is happening in the U.S. we hope that we don't have to follow the same pattern in getting regulation on top of regulation.

MR. LAWRENCE M. AGIN: This may be a little off topic but I was wondering with all this talk about the state departments and their different requirements some of which seem to be rather arbitrary, if anyone on the panel would care to comment about the laws that are in congress now for Federal regulation and whether you might think that would be any improvement. Possibly Federal regulation could be limited to health or certain parts of insurance and not to life if that was a distinction that we wanted. I was wondering if you were in favour or against Federal regulation.

MR. BURGESS: My personal feeling is that there is no question that the regulations of the various states do cause a lot of problems. We honestly feel that working within the framework of the NAIC to try to get as much uniformity as is possible is still the way to go. We feel that if we are forced to deal with the Federal government the laws and regulations to which we will be subjected will not give the insurance industry enough of the type of freedom that it has to have in a free enterprise society. The more you work with the Federal government the less and less ability you have to try to do something within that system. Now I agree with Lear that I don't think the responsibility of regulation is solely with the regulators, I think we've got some of that responsibility too. We must work with whomever we have to work with for the betterment of the consumer as well as well as for our own interest but I think that if we get the Federal government involved they are going to want to run things. A real danger we have is a layer of Federal regulation on top of the layers of state regulation which would just add to the problem we have in dealing with consumerism and regulation.

MR. VINCENT W. DONNELLY: One comment on that last point. I think we in the United States who have recently seen the releases by the EEOC dealing with maternity and by the Department of Labour and EEOC in the area of age discrimination, probably can see that Federal regulation is not going to be a utopia and that when it does come it will be massive in its impact. Second comment, as in the blindness regulation and in the handicap regulation, the regulators have now settled in on a comment that rate classification is justified if it is in compliance with sound actuarial principles. Working on the staff of the Council in dealing with the regulators, I haven't been able to determine within the Society of Actuaries any indication that sound actuarial principles can be defined. I was wondering if Will or Mr. Carstens cared to comment on this trend as to whether or not actuaries will be called upon to now define a term that perhaps is undefinable.

MR. BURGESS: Frankly, this scares me too. Again, we've got the situation where we have actuaries taking various views. What one may

view as sound actuarial principles another, in another position, may not feel is a sound actuarial principle. I think the question is "how is the regulator to know?" With that very vaguely defined term how is he going to view the insurance company actuary who is trying to justify classification systems when the regulator may be opposed from the standpoint of social acceptability and political considerations. You can have two actuaries starting from opposite viewpoints who can justify to themselves a rating and classification system to support their views but they may each find ways to knock holes in each other's systems. When you have that combined with this vaguely defined term, and this is one of the things with this Michigan Regulation that's in the wind now, it is very difficult to understand this type of regulation. The thing that really scares me as a company actuary is just what does it mean and just how much leeway does a company actuary have for devising sound risk and classification systems.

MR. PETERSON: Maybe it is a responsibility of the Academy of Actuaries if it's not the Society of Actuaries, but here we are dealing with the Federal or the state regulatory area, and someone- a legislator - is putting down the word actuarial principle. Are we going to have the legislators tell us what the actuarial principles are or are we going to have some sort of organization of actuaries address this question? It seems as though when the question comes up in the pension area there are more actuarial style organizations willing to speak about the matter, not to mention the accounting organizations. In life insurance we've got the accountants and the actuaries speaking. I guess we've got a society or academy committee addressing what a dividend is now. No one knew what a dividend was before but apparently there are good dividends and bad dividends and we are going to find out more about that but it seems as though health insurance has been the orphan in this particular area as far as actuarial principles are concerned.

MR. BURGESS: I know the Academy has addressed itself to this problem. Is there anybody who can enlighten us on the Academy's position, not the Academy per se, but the Academy has had a committee working on this problem of discrimination.

MR. ROBERT SHAPLAN: I am a member of that committee but we have not had our first meeting. Our first meeting is in about two weeks from now.

MR. WILLIAM R. BURNS: It seems to me with respect to this problem of classification that the Society of Actuaries is the body that should itself to the problems of classification or you could almost say declassification. As Mr. Shaplan mentioned, I understand that the Academy does have a committee working on this but I believe that the Society also has a committee on risk classification. I happen to believe that while you could argue for the Academy here, I believe that it is really the Society that should take the ball more in this very important area, particularly in health insurance. On the regulatory side, both on an individual state basis and I believe on the NAIC level, whenever a situation such as this classification develops and presents itself it is the highly professional body of the Society of Actuaries, the real blue chip body, to which the regulators rely and relate. They expect and hope for a definite scientific expression from the top drawer of professional scientific body. I have

seen one or two outlines of this problem from the Society. I think that the better job could be done by our Society in defining what the problems are and establishing minimum standards of classifications, such as sex, in the case of accident and health insurance and age, particularly in the case of life insurance and annuities. I think that only a professional body of actuaries without necessarily an axe to grind, as naturally you would expect the Academy to have, can make these definitions and declarations of needed minimum classifications for the proper administration of insurance. Otherwise unacceptable inequities are likely to result. So I would strongly urge the Society to take the bull by the horns, I think just a little more than the Society has to date. I do believe that it would be listened to by most regulatory publics. It is inaction and uncertainty on the part of the actuaries that, I think, is adding to the problem areas in this risk classification situation.