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RISK CLASSIFICATION AND PRIVACY

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1. What are the implications of the Privacy Study Commission's recommendations?

2. What legislative developments have occurred? What can be expected? The Academy Task Force Report on Risk Classification: What are the fundamental principles of classification? If experimentation in classification is prohibited, how can modifications be justified?

3. If it is feasible to do so, should we take an amicus curiae position in risk classification court cases?

4. Do the traditional state anti-discrimination laws need to be made more specific?

MR. ORLO L. KARSTEN, JR.: Common usage has made "discrimination" a dirty word within our world of insurance. We persist in another definition of the word, saying that while critics charge us with unfair discrimination, we practice fair discrimination. Underwriters do make intelligent distinctions in risk classification, and that is fair discrimination. However, I am afraid we are only playing with semantics. Whether fair or unfair, discrimination is a dirty word -- or so say the critics. Fairly or unfairly, the risk classification process is labeled as discriminatory.

If you want to gain some insight on the populist view of discrimination, you have only to look at the employment practices of your own company. If you have not been close to that for several years, you may find some surprising changes.

You are probably aware that employment tests of an aptitude nature are not used any more. You will also learn there are a number of questions which are not asked on the application for employment, and which are not to be raised in employment interviews. The general concern is that if such information were obtained, it might be used unlawfully. If your company inquired into these areas, there would be a risk of providing evidence for charges of discrimination against the company.

The law of the land is that females and racial minorities cannot be discriminated against. Therefore, job applicants cannot be asked questions with racial or sexist implications. For example, the color of hair or eyes are not on the employment form for these factors are not related to the performance of any job, and might be used as an indication of an employee's race or religion.

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Another example: marital status is irrelevant. Some employers had refused to hire married women for certain jobs, and that is now a violation of Title VII of the Civil Rights Act. It is improper to ask if the applicant is widowed or divorced, for a larger proportion of women in the labor force, and a larger proportion of blacks are divorced. Therefore, responses to the question could adversely affect women and blacks.

The Age Discrimination in Employment Act prohibits discrimination against individuals aged 40 through 64. If age or date of birth is asked on the employment application, for other purposes, it is probably necessary to call this law to the applicant's attention.

Do not ask about arrest records which may not be related to guilt. The question could be racially oriented, for historically, minorities have suffered proportionately more arrests than others. Asking about convictions is probably unlawful, if it implies an absolute bar to the employment of an applicant who has a conviction record. Similarly, has a fidelity bond ever been refused? The Maryland Commission on Human Relations has issued an order prohibiting an employer from asking about bond refusals because it may have a discriminating impact.

Perhaps those are enough examples to illustrate that discrimination in any form, fair or otherwise, is simply not permitted in the employment practices of insurance companies or any other employer.

I would point out that employment is not a guaranteed contract for life. Any employee can be terminated when work performance is not up to standards, but of course there cannot be discrimination in employee terminations.

By contrast, a life insurance policy is a guarantee for life. Once insured, a policyowner cannot be dismissed for unsatisfactory performance.

Which brings me to the actuarial and underwriting areas of our companies, where we have views on discrimination which are different from those in the personnel department. For example, the marital status of an insurance applicant does have a material bearing on insurable interest in the policy proceeds.

A long tradition of practicing fair discrimination holds that insurance applicants can be placed in appropriate risk classes. What factors determine those classes?

1. Family history - heredity is associated with diabetes and early deaths from coronary artery disease.

2. Medical history - serious illness does cause deaths.

3. Current medical findings - overweight or elevated blood pressure do reduce longevity.

4. Occupations - there are still some with unusual health or safety hazards.

5. Avocations - the use of leisure time is now more of an insurance factor than occupation.

6. Driving habits - accidental deaths are high.

7. Financial affairs - if the amount of insurance is unreasonable for an applicant, a few premium dollars can be gambled against a large amount of insurance.

Those are some of the factors which determine risk classes. As underwriters and actuaries know, the relative importance of each factor is decided by each highly individualistic company in our competitive business.

Special mention must be made of two other risk factors: age and sex.

I assume everyone in this room is aware of the recent decision by the U.S. Supreme Court, that women cannot be required to contribute more than men to an employer's pension plan. It is certain that the controversy on unisex mortality tables will escalate. If required for contributing pension plans, will they also become mandated for other pension plans, and for risk classification?

In press releases about the Supreme Court decision, there was an aspect which I interpreted this way: averages are interesting, such as the "fact" that women live longer than men, but such averages do not apply to the individual.

Literally then, the individual man can out-survive an individual woman. True. By the same logic, an 80 year old can outlive a 20 year old. True? An 80 year old with a terminal disease can outlive a 20 year old with no known health or other underwriting impairments. True??

If this sounds a little far-fetched, I would remind you that Massachusetts auto companies face the possibility of rating an individual on his own past claim experience. As Ken Mitchem of the Metropolitan pointed out, on this principle all life risks will be considered standard so long as they have died fewer than the average number of times!

Earlier I referred to life insurance as a lifetime contract. At the time of application for insurance, a number of questions are asked and a great deal of information is gained, to place the applicant in a fair and equitable risk class. That class can improve, as when the person insured leaves a hazardous occupation. However, the person can never be put in a higher risk class, as with deteriorating health.

The class is largely determined at the one point in time, at application. Underwriting artists draw a sketch of the person at that moment of time. If they do their job well, the sketch is a very good likeness even if not as sharply defined as a photograph.

In drawing a sketch today, I hope one image stays with you. Insurance is insurance is insurance. What is the difference between casualty and life insurance? Insurance is a necessity. I must have insurance on my car, and my home. Ergo, I must have insurance on my life. And if insurance is a necessity, then it is like all other necessities to which I am entitled. And since I am entitled to as much as anyone else, I should not pay any more than anyone else. If some exploitative insurance company wants me to pay more than

anyone else, the government must pay. After all, we all know there is plenty of free government money just for the asking. I want mine.

MRS. LINDA B. EMORY: We wish to alarm you. Alarm you with an understanding of what is currently happening that can impact our risk classification system. Alarm you with the need to work to preserve those classification elements essential to our industry. Alarm you to look into your classification system and eliminate those elements that could be considered discriminatory to the public and which may be no longer justified. Alarm you to consider the consequences of major restrictions on our classification process. Regulative, legislative, litigative and rhetorical actions of late should alarm us that our classification principles are slipping.

At the federal level, most recent activity has had to do with employee benefit plans and sex discrimination. Although the group insurance mechanism is better able to handle equality of payments and benefits, some individual products are used, and the danger is spillover to our individual classification system. At the federal level, there are basically two different areas under scrutiny and where the Supreme Court has rendered decisions.

The first is with regard to pension plans - the so-called "unisex" issue. The Supreme Court has just heard the Manhart versus City of Los Angeles case on this subject. Here the Supreme Court did find the requirement that men and women make unequal contributions to an employer-operated pension fund was discriminatory and violated Title VII of the 1964 Civil Rights Act. The opinion does emphasize that it is unlawful to discriminate against any individual. This precludes treatment of individuals as simply components of a racial, religious, sexual, or national class, even where there are class differences in longevity. We do, however, believe the amicus curiae brief filed on behalf of the Academy and the Society with regard to the Manhart case accomplished its purpose. The brief did make the Court aware of certain principles of insurance and risk classifications. It encouraged the Court to limit its opinion to the narrow scope of Title VII - that is, to employment discrimination. The opinion did not deal with the use of unisex tables. They expressly acknowledged the use of sex-related estimates. They seemed to accept equal monthly benefits for both male and female employees. They expressly permitted equal defined contributions, with purchase on the open market of unequal monthly benefits at retirement. Their general posture was one of not attempting to revolutionize the insurance and pension industries. The actuarial function of estimating retirement plan costs seemed to be properly recognized.

We probably have not heard the end of the unisex issue. The EEOC and the Commission on Civil Rights have advocated that unisex pricing be required so that employers would not be discouraged from hiring women because of their higher insurance costs. Further litigation is pending, and legislation could be sought at any time.

The second type of activity at the federal level with regard to employee benefits has to do with so-called discrimination because of pregnancy. In the Gilbert versus General Electric case, the Supreme Court found that the exclusion of pregnancy coverage in an employee disability plan did not constitute discrimination by sex. The reasoning is that the differentiation is not between men and women but between pregnant women and non-pregnant persons

(non-pregnant persons can be both men and women). Since the Gilbert decision did not please the public, legislation was introduced in Congress to overturn the decision. This legislation, which has been passed by the Senate, would require employers to provide both disability and medical expense coverage for normal pregnancy on the same basis as they provide for illness. This bill is currently before the House in a somewhat modified form. The insurance industry trade organizations testified with regard to the bill when it was before the Senate. They pointed out the cost of these benefits, which will ultimately be borne by the public. They suggested amendments to keep costs under control. They were totally ignored. Interestingly, employers did not come forth to testify against the bill. Apparently, this would be a most unpopular thing to do. At any rate, it is entirely probable that mandatory maternity coverage for normal births, paid by employers, will become a reality soon.

The HEW has proposed rules which prohibit discrimination against handicapped persons under any program or activity receiving federal financial assistance. There is also the federal law regarding age discrimination in employment. All of these employee benefit discrimination issues have the potential of spilling over into our individual risk classification process. It is important for our actuarial organizations to point out to the Courts any unforeseen consequences which sweeping decisions might cause our industry, as we did in the Manhart brief.

Also at the national level, it is interesting to note that the U.S. Commission on Civil Rights recently held a "consultation" on Discrimination in the Insurance Industry. The discrimination issues discussed included not only employment practices but availability of coverages, risk classification practices, marketing approaches, and whether rating differences really fairly reflect costs. Our industry views were presented by four actuaries and our trade organizations. But also appearing were Herbert Dennenberg, State Regulators, Women's Rights Advocates, and others who were not particularly happy about our practices. The very fact that employment discrimination and risk classification seem to be lumped together bears evidence that our risk classification system is under attack.

Risk classification in individual life and health insurance has been governed by the anti-discrimination provisions of the Unfair Trade Practices Acts, which are in effect in all states. These laws prohibit "unfair discrimination" between individuals of the same class with equal expectation of life (or, in the case of health, with essentially the same hazard). The prohibition is with regard to rates, dividends, benefits and terms and conditions of the contract. These laws mandate equity, rather than equality, in risk classification.

Individual life and health insurance are voluntary mechanisms through which individuals avoid the risk of catastrophic loss resulting from accident, sickness or death by paying premiums to a common fund. For our voluntary form of insurance to work in a free enterprise system, each insured must contribute his equitable share to the common fund, depending upon the risk he brings to the fund. If an insured feels he is paying more than his fair share, he has the opportunity to seek a better arrangement from another insurer or to not participate at all. If only poorer risks remain in the pool, the contributions to the fund would eventually not meet the claims, and the system would collapse.

The only way a pool with equal contributions among different classes of risks could work, would be to mandate participation or to provide subsidy from an outside source, such as in social insurance or in group employee benefit insurance.

The general public does not understand the reason for our individual classification system and it is no wonder. The public is confused because they pay equal amounts to their group plan regardless of age, sex, or health -- they do not realize that the employer subsidization of the plan is what makes it work. We need to communicate these principles.

There is a tendency for the general public to feel an individual should not be penalized for something which is not in his control such as sex or physical handicap. Some believe that guaranteeing individual rights precludes classification for any purpose, including insurance. There are today special interest groups which lobby against "discrimination" toward their particular impairment. I have recently seen a "Study of Discrimination Against Cancer Patients" and a "Plan for Nationwide Action on Epilepsy". There is an NAIC Task Force on Unfair Discrimination Against the Blind. HEW Secretary Califano has proposed non-smoking incentives by our industry. These special interest groups feel that they deserve insurance at the same rate or a better rate than others pay. These are emotional issues which are hard to fight.

In addition to state legislation against unfair discrimination by race and sex, there have been quite a few state laws and regulations recently which prohibit additional considerations in classifying risks. For instance, some prohibit rating or rejection for sickle cell trait, severe disability, mental or physical handicap, blindness, deafness or similar impairments. Others do not prohibit ratings, but require that they be based on sound actuarial principles, a reasonable classification system related to actual or credible claims experience. There is a tendency for a bill passed in one state to be picked up in another or expanded from one special interest group to another. Therefore, it is important to try to keep wording as consistent as possible and as fair and equitable to all parties as possible. The interpretation of what is meant by such terms as "sound actuarial principles", "reasonable classification system" and "credible claims experience" is rather frightening. We are really assuming that these bills are going to be interpreted in fairly favorable terms, because unfavorable interpretation or a run by the special interest groups could be rather devastating.

There is an ACLI-HIAA Model Risk Classification Bill which has been developed by the Joint Risk Classification Committees. It is currently authorized for use in opposing adverse bills. If used affirmatively it could help minimize differences by states and discourage narrow special interest legislation. The wording, though, is subject to unfavorable interpretation.

The Model Bill is designed to expand on the Unfair Trade Practices Act. It defines unfair practices, among other things, as refusing to insure or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual or charging a different rate based on age, handicap, occupation or residence, except where based on sound actuarial principles or a reasonable system of classification or is related to actual or reasonably anticipated experience.

The ACLI-HIAA is obviously not completely comfortable with this bill but it is preferable to some of the wording the states are developing. The

Committee would like to see the bill proposed to the NAIC since they advocate taking a positive approach. It is very unpopular and almost impossible to stop legislation favoring a special interest group which has the public's and the Commissioner's sympathy.

Unfortunately, our risk classification systems are not perfect. They are subject to attack that:

1. We do not sufficiently recognize mortality differences of non-smokers and very fit individuals.

2. We pay too much attention to weight, blood pressure, and various health impairments and not enough to more sophisticated measures.

3. Practices may vary significantly from one insurance company to another.

4. We often do not have hard statistics to back up our actions. Ratings require judgment as to probable future effect on mortality. In some cases, perhaps, we have not responded quickly enough to medical improvements.

The Academy Task Force on Risk Classification recommended an industry study of the classification systems now being used, to substantiate or invalidate their credibility. Since the states are relying on "sound actuarial principles" and "actuarial experience", it behooves the actuarial profession to have strong principles and enough experience to justify our practices.

It is important for us to realize that some of the social attitudes which underlie the challenge to our classification system are on a collision course with the fundamentals of our industry. We must reappraise our system, determine the elements essential to our existence, but continue to meet the needs of our markets and the public in general. We all need to do our part to stay on top of this situation.

MR. LAVERNE W. CAIN: I will concentrate my comments on the practical problems of complying with the 17 recommendations made by the President's Privacy Protection Study Commission which deal specifically with the insurance industry.

The Commission did recognize the need for insurance companies to obtain information about individuals. The following quote summarizes its basic findings with respect to insurance companies and privacy:

> "As is evident from the preceding sections, the insurance industry is highly dependent upon recorded information about individuals. This dependence creates a number of privacy protection problems, some of which are inherent in the insurance system, but can be controlled, and some of which present real or potential abuses that need to be eliminated."

The Commission's recommendation had three stated objectives.

(1) to create a proper balance between what an individual is expected to divulge about himself to a recordkeeping orgainzation and what he seeks in return.

Basically this objective seeks to minimize intrusiveness.

(2) to open up recordkeeping operations in ways that will minimize the extent to which recorded information about an individual is itself a source of unfairness in any decision about him made on the basis of such information.

This objective seeks to maximize fairness by encouraging the collection, use and disclosure of higher quality information.

(3) to create and define obligations with respect to the uses and disclosures that will be made of recorded personal information.

This objective seeks to create a duty of confidentiality.

The first three Commission recommendations relate to the scope and character of the inquiry to which an insurer may require an individual to submit as a condition of establishing or maintaining an insurance relationship.

Recommendation (1) states:

> That governmental mechanisms should exist for individuals to question the propriety of information collected or used by insurance institutions, and to bring such objections to the appropriate bodies which establish public policy. Legislation specifically prohibiting the use, or collection and use, of a specific item of information may result; or an existing agency or regulatory body may be given authority, or use its currently delegated authority, to make such a determination with respect to the reasonableness of future use, or collection and use, of a specific item of information.

This recommendation would establish "governmental mechanisms" for individuals to question the propriety of information collected or used by insurance companies. I think it is significant that the recommendation uses the word "propriety" rather than "relevance". Apparently the Commission recognized that certain items of information might be relevant to a decision but that society today or in the future might consider their collection or use objectionable on other grounds. In other words, some information may be considered to be so personal, that even if relevant, it should not be collected.

The danger in this recommendation is that legislation enacted at the state or federal level will take away our right to collect and use relevant information. I believe there is a real need for the insurance industry to communicate to the public and to our legislators why certain information is needed and how its collection and use is beneficial to the insurance buying public as a whole.

Recommendation (2) states:

> That the Federal Fair Credit Reporting Act be amended to provide that no insurance institution or insurance-support

> organization may attempt to obtain information about an individual through pretext interviews or other false or misleading representations that seek to conceal the actual purpose(s) of the inquiry or investigation, of the identity or representative capacity of the inquirer or investigator.

This recommendation would appear to have minimal impact on life and health insurers. It might have some limited impact on the investigation of certain disability claims.

Recommendation (3) states:

> That the Federal Fair Credit Reporting Act be amended to provide that each insurance institution and insurance-support organization must exercise reasonable care in the selection and use of insurance-support organizations, so as to assure that the collection, maintenance, use, and disclosure practices of such organizations comply with the Commission's recommendations.

This recommendation relates to organizations like the Medical Information Bureau and inspection companies. I have not heard anyone argue against this recommendation.

The next 13 recommendations relate to the objective of maximizing fairness. Many of these recommendations are controversial and are currently being debated within the industry.

Recommendation (4) states:

> That each insurance institution and insurance-support organization, in order to maximize fairness in its decision-making processes, have reasonable procedures to assure the accuracy, completeness, and timeliness of information it collects, maintains, or discloses about an individual.

This recommendation advocates voluntary self-regulation and applies to insurance companies as well as support organizations. In the narrative text the Commission indicated that they did not recommend that Recommendation (4) be incorporated in statute or regulation. It envisioned Recommendation (4) being implemented automatically as a result of its other recommendations.

Recommendation (5) states:

> That an insurance institution, prior to collecting information about an applicant or principal insured from another person in connection with an insurance transaction, notify him as to:
>
> (a) the types of information expected to be collected about him from third parties and that are not collected on the application, and, as to information regarding character, general reputation, and mode of living, each area of inquiry;

(b) the techniques that may be used to collect such types of information;

(c) the types of sources that are expected to be asked to provide each type of information about him;

(d) the types of parties to whom and circumstances under which information about the individual may be disclosed without his authorization, and the types of information that may be disclosed;

(e) the procedures established by statute by which the individual may gain access to any resulting record about himself;

(f) the procedures whereby the individual may correct, amend, delete, or dispute any resulting record about himself;

(g) the fact that information in any report prepared by a consumer-reporting agency (as defined by the Fair Credit Reporting Act) may be retained by that organization and subsequently disclosed by it to others.

Note that this recommendation refers to information about an individual from other than the individual, i.e., third parties. This would severely limit investigations since it would require an insurer to notify an applicant as to all the types of sources which could be contacted and the types of information which might be collected from these sources.

This recommendation would broaden current pre-notification procedures and require a more elaborate pre-notification statement. Is this necessary and what effect would this have on the sales process? Many observers feel that the current pre-notification procedures are adequate and that a more elaborate procedure would confuse applicants and hinder the agent from making the sale.

Notice would not have to be given in connection with the collection of information where the information was not to be used in an insurance transaction. An insurance transaction is defined as whenever a decision is rendered regarding an individual's eligibility for an insurance benefit or service. Thus no notice would be required to gather marketing information or when some non-decision making service is provided such as an address change or change in beneficiary.

Although the recommendation itself does not exempt claim transactions from this pre-notice requirement, the accompanying discussion makes it clear that the recommendation does not apply to claim transactions.

Recommendation (6) states:

That an insurance institution limit:

(a) its own information collection and disclosure

practices to those specified in the notice and called for in Recommendation (5); and

(b) its request to any organization it asks to collect information on its behalf to information, techniques, and sources specified in the notice called for in Recommendation (5).

This recommendation limits an insurer's inquiry to the information collection and disclosure practices specified in the notice. Like Recommendation (5), this recommendation does not apply to information collected for marketing purposes or to claims investigations.

Recommendation (7) states:

> That any insurance institution or insurance-support organization clearly specify to an individual those items of inquiry desired for marketing, research, or other purposes not directly related to establishing the individual's eligibility for an insurance benefit or service being sought and which may be used for such purposes in individually identifiable form.

The Commission feels that an individual should be advised of items of information desired which will not affect his insurability. I do not believe that compliance with this recommendation presents any major problems.

Recommendation (8) states:

> That no insurance institution or insurance-support organization ask, require, or otherwise induce an individual, or someone authorized to act on his behalf, to sign any statement authorizing any individual or institution to disclose information about him, or about any other individual, unless the statement is:
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> (a) in plain language;
>
> (b) dated;
>
> (c) specific as to the individuals and institutions he is authorizing to disclose information about him who are known at the time the authorization is signed, and general as to others whose specific identity is not known at the time the authorization is signed;
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> (d) specific as to the nature of the information he is authorizing to be disclosed;
>
> (e) specific as to the individuals or institutions to whom he is authorizing information to be disclosed;

(f) specific as to the purpose(s) for which the information may be used by any of the parties named in (e), both at the time of the disclosure and at any time in the future;

(g) specific as to its expiration date which should be for a reasonable period of time not to exceed one year, and in the case of life insurance or noncancelable or guaranteed renewable health insurance, two years after the date of the policy.

This recommendation which calls for a limited authorization form presents several problems. First, it would seem difficult to prepare an authorization that meets the requirements. In some cases we may have to go back to an applicant for an additional authorization which would delay the processing of the application. One of the dangers of this type of recommendation is that it allows an applicant to control, to some extent, what information is available to the insurer. An applicant who wanted to conceal an aspect of his insurability could presumably do so by limiting the individuals authorized to disclose information and/or the nature of the information authorized to be disclosed.

Recommendation (9) states:

> That the Federal Fair Credit Reporting Act be amended to provide that any insurance institution that may obtain an investigative report on an applicant or insured inform him that he may, upon request, be interviewed in connection with the preparation of the investigative report. The insurance institution and investigative agency must institute reasonable procedures to assure that such interviews are performed if requested. When an individual requests an interview and cannot reasonably be contacted, the obligation of the institution preparing the investigative report can be discharged by mailing a copy of the report, when prepared, to the individual.

This recommendation requires a direct interview with the applicant, if requested. This is usually done and is desirable when possible. In some cases a direct interview will delay handling of the case and approval of the insurance application. Where a direct interview cannot be obtained in a reasonable time, the report can be prepared and a copy of the report mailed to the individual.

Recommendation (10) states:

> That the Federal Fair Credit Reporting Act be amended to provide:
>
> (a) That, upon request by an individual, an insurance institution or insurance-support organization must:
>
> (i) inform the individual, after verifying his identity, whether it has any recorded information pertaining to him; and

(ii) permit the individual to see and copy any such recorded information, either in person or by mail; or

(iii) apprise the individual of the nature and substance of any such recorded information by telephone; and

(iv) permit the individual to use one or the other of the methods of access provided in (a)(ii) and (iii) or both if he prefers.

The insurance institution or insurance-support organization may charge a reasonable copying fee for any copies provided to the individual. Any such recorded information should be made available to the individual, but need not contain the name or other identifying particulars of any source (other than an institutional source) of information in the record who has provided such information on the condition that his identity not be revealed, and need not reveal a confidential numerical code.

(b) That notwithstanding part (a), with respect to medical-record information maintained by an insurance institution or an insurance-support organization, an individual has a right of access to that information, either directly or through a licensed medical professional designated by the individual, whichever the insurance institution or support organization prefers.

This recommendation broadens existing disclosure procedures to require that both insurance companies and insurance-support organizations give individuals access to information contained on them in their files. This information could be received by mail, telephone, or in person.

Medical information can be made available, at the option of the company, either directly to the individual or to a licensed physician designated by the individual. This can present a problem when the medical information was obtained from another medical source. If we release information without an authorization from the provider, we might be vulnerable to suit by the provider or to lack of future cooperation in obtaining information from that source.

This recommendation may create some invasion of privacy problems since information in an individual's file may also contain personal information about others. For example, there may be information about a beneficiary, employer, or business associate in the file.

Also this recommendation would apply to records of employees, agents, or brokers held by the company.

Recommendation (11) states:

> That the Federal Fair Credit Reporting Act be amended to provide that each insurance institution and insurance-support organization permit an individual to request correction, amendment, or deletion of a record pertaining to him; and
>
> (a) within a reasonable period of time:
>
> (i) correct or amend (including supplement) any portion thereof which the individual reasonably believes is not accurate, timely, or complete; and
>
> (ii) delete any portion thereof which is not within the scope of information the individual was originally told would be collected about him; and
>
> (b) furnish the correction, amendment, or fact of deletion to any person or organization specifically designated by the individual who may have, within two years prior thereto, received any such information; and, automatically to any insurance-support organization whose primary source of information on individuals is insurance institutions when the support organization has systematically received any such information from the insurance institution within the preceding seven years, unless the support organization no longer maintains the information, in which case, furnishing the correction, amendment, or fact of deletion is not required; and automatically to any insurance-support organization that furnished the information corrected, amended, or deleted; or
>
> (c) inform the individual of its refusal to correct or amend the record in accordance with his request and of the reason(s) for the refusal; and
>
> (i) permit an individual who disagrees with the refusal to correct or amend the record to have placed on or with the record a concise statement setting forth the reasons for his disagreement; and
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> (ii) in any subsequent disclosure outside the insurance institution or support organization continuing information about which the individual has filed a statement of dispute, clearly note any portion of the record which is disputed, and provide a copy of the statement along with the information being disclosed; and
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> (iii) furnish the statement of dispute to any person or organization specifically designated by the individual who may have, within two years prior thereto, received any such information; and, automatically, to an

> insurance-support organization whose primary source of information on individuals is insurance institutions when the support organization has received any such information from the insurance institution within the preceding seven years, unless the support organization no longer maintains the information, in which case, furnishing the statement is not required; and automatically, to any insurance-support organization that furnished the disputed information;
>
> (d) limit its reinvestigation of disputed information to those record items in dispute.

This recommendation spells out in detail how corrections should be made to records of insurance companies or insurance-support organizations. Companies do want their records to be accurate and compliance with this recommendation should not be difficult or require many changes from current practice.

Recommendation (12) states:

> That notwithstanding Recommendation (11)(a)(i), if an individual who is the subject of medical-record information maintained by an insurance institution or insurance-support organization requests correction or amendment of such information, the insurance institution or insurance-support organization be required to:
>
> (a) disclose to the individual, or to a medical professional designated by him, the identity of the medical-care provider who was the source of the medical-record information; and
>
> (b) make the correction or amendment requested within a reasonable period of time, if the medical-care provider who was the source of the information agrees that it is inaccurate or incomplete; and
>
> (c) establish a procedure whereby an individual who is the subject of medical-record information maintained by an insurance institution or insurance-support organization, and who believes that the information is incorrect or incomplete, would be provided an opportunity to present supplemental information of a limited nature for inclusion in the medical-record information maintained by the insurance institution or support organization, provided that the source of the supplemental information is also included.

This recommendation concerns correction of file information which is medical-record information. I do not believe compliance with this recommendation presents any significant problems to companies.

The text material indicates that Recommendations (10), (11) and (12) would not apply to records for use in settling a claim while the claim remains unsettled.

Recommendation (13) states:

> That the Federal Fair Credit Reporting Act be amended to provide that an insurance institution must:
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> (a) disclose in writing to an individual who is the subject of an adverse underwriting decision:
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> (i) the specific reason(s) for the adverse decision;
>
> (ii) the specific item(s) of information that support(s) the reason(s) given pursuant to (a)(i), except that medical-record information may be disclosed either directly or through a licensed medical professional designated by the individual whichever the insurance institution prefers;
>
> (iii) the name(s) and address(es) of the institutional source(s) of the item(s) given pursuant to (a)(ii); and
>
> (iv) the individual's right to see and copy, upon request, all recorded information concerning the individual used to make the adverse decision, to the extent recorded information exists;
>
> (b) permit the individual to see and copy, upon request, all recorded information pertaining to him used to make the adverse decision, to the extent recorded information exists, except that (i) such information need not contain the name or other identifying particulars of any source (other than an institutional source) who has provided such information on the condition that his or her identity not be revealed, and (ii) an individual may be permitted to see and copy medical-record information either directly or through a licensed medical professional designated by the individual, whichever the insurance institution prefers. The insurance institution should be allowed to charge a reasonable copying fee for any copies provided to the individual;
>
> (c) inform the individual of:
>
> (i) the procedures whereby he can correct, amend, delete, or file a statement of dispute with respect to any information disclosed pursuant to (a) and (b); and

(ii) the individual's rights provided by the Fair Credit Reporting Act, when the decision is based in whole or in part on information obtained from a consumer-reporting agency (as defined by the Fair Credit Reporting Act);

(d) establish reasonable procedures to assure the implementation of the above.

This recommendation requires disclosure in writing in every situation involving an adverse underwriting decision. An adverse underwriting decision is defined as follows:

- With respect to life and health insurance, a denial of requested insurance coverage (except claims) in whole or in part or an offer to insure at other than standard rates; and with respect to all other kinds of insurance, a denial of requested insurance coverage (except claims) in whole or in part, or a rating which is based on information which differs from that which the individual furnished; or

- A refusal to renew insurance coverage in whole or in part; or

- A cancellation of any insurance coverage in whole or in part.

A few companies are providing written disclosure now but most companies only do this on request. In some situations this could result in repeated correspondence and dissatisfaction on the part of the applicant and agent.

Recommendation (14) states:

That no insurance institution or insurance-support organization:

(a) make inquiry as to:

(i) any previous adverse underwriting decision on an individual, or

(ii) whether an individual has obtained insurance through the substandard (residual) insurance market,

unless the inquiry requests the reasons for such treatment; or

(b) make any adverse underwriting decision based, in whole or in part, on the mere fact of:

(i) a previous adverse underwriting decision, or

(ii) an individual having obtained insurance through the substandard (residual) market.

> An insurance institution may, however, base an adverse underwriting decision on further information obtained from the source, including other insurance institutions.

This recommendation prohibits inquiries regarding previous adverse underwriting decisions unless the reasons for such action are developed. A current decision can not be made solely on a previous adverse decision, but an adverse decision could be made after developing further information from the source. This recommendation should not present any significant problems to companies.

Recommendation (15) states:

> That no insurance institution base an adverse underwriting decision, in whole or in part, on information about an individual it obtains from an insurance-support organization whose primary source of information is insurance institutions or insurance-support organizations; however, the insurance institution may base an adverse underwriting decision on further information obtained from the original source, including another insurance institution.

The Commission was concerned about violations of the rules of the Medical Information Bureau. Since this recommendation conforms to current MIB rules, companies should all be complying with this recommendation.

Recommendation (16) states:

> That federal law be enacted to provide that no insurance institution or insurance-support organization may disclose to another insurance institution or insurance-support organization information pertaining to an individual's medical history, diagnosis, condition, treatment, or evaluation, even with the explicit authorization of the individual, unless the information was obtained directly from a medical-care provider, the individual himself, his parent, spouse, or guardian.

This recommendation prohibits a company or insurance-support organization from disclosing to another company or insurance-support organization information pertaining to an individual's health, even with the authorization of the individual, if the information was obtained from a lay source. Obviously medical-type information needs to be handled with confidentiality and information from a lay source is generally not as reliable as information from a medical source.

This recommendation would prevent agents or an inspection company from providing us with health information. Although not a frequent occurrence, information of this type is often important, particularly as it relates to drug or alcohol usage.

Recommendation (17) states:

> That federal law be enacted to provide that each insurance institution and insurance-support organization be considered to owe a duty of confidentiality to any individual about whom it collects or receives information in connection with an insurance transaction, and that therefore, no insurance institution

or support organization should disclose, or be required to disclose, in individually identifiable form, any information about any such individual without the individual's explicit authorization, unless the disclosure would be:

(a) to a physician for the purpose of informing the individual of a medical problem of which the individual may not be aware;

(b) from an insurance institution to a reinsurer or co-insurer, or to an agent or contractor of the insurance institution, including a sales person, independent claims adjuster, or insurance investigator, or to an insurance-support organization whose sole source of information is insurance institutions, or to any other party-in-interest to the insurance transaction provided:

(i) that only such information is disclosed as is necessary for such reinsurer, co-insurer, agent, contractor, insurance-support organization, or other party-in-interest to perform its function with regard to the individual or the insurance transaction;

(ii) that such reinsurer, co-insurer, agent, contractor, insurance-support organization or other party-in-interest is prohibited from redisclosing the information without the authorization of the individual except, in the case of insurance institutions and insurance-support organizations, as otherwise provided in this recommendation; and

(iii) that the individual, if other than a third-party claimant, is notified at least initially concurrent with the application that such disclosure may be made and can find out if in fact it has been made; and

(iv) that in no instance shall information pertaining to an individual's medical-history, diagnosis, condition, treatment, or evaluation be disclosed, even with the explicit authorization of the individual, unless the information was obtained directly from a medical-care provider, the individual himself, or his parent, spouse, or guardian;

(c) from an insurance-support organization whose sole source of information is insurance institutions or self-insurers to an insurance institution or self-insurer, provided;

(i) that the sole function of the insurance-support organization is the detection or prevention of insurance fraud in connection with claim settlements;

(ii) that, if disclosed to a self-insurer, the self-insurer assumes the same duty of confidentiality with regard to that information which is required of insurance institutions and insurance-support organizations; and

(iii) that any insurance institution or self-insurer that receives information from any such insurance-support organization is prohibited from using such information for other than claim purposes;

(d) to the insurance regulator of a state or its agent or contractor, for an insurance regulatory purpose statutorily authorized by the state;

(e) to a law enforcement authority:

(i) to protect the legal interest of the insurer, reinsurer, co-insurer, agent, contractor, or other party-in-interest to prevent and to prosecute the perpetration of fraud upon them; or

(ii) when the insurance institution or insurance-support organization has a reasonable belief of illegal activities on the part of the individual;

(f) pursuant to a federal, state, or local compulsory reporting statute or regulation;

(g) in response to a lawfully issued administrative summons or judicial order, including a search warrant or subpoena.

This recommendation is designed to meet the Commission's third policy objective relating to confidentiality.

Essentially this recommendation requires that no insurance company or insurance-support organization should disclose in individually identifiable form any information about an individual without the individual's explicit authorization. The Commission listed several situations where exceptions to the requirements were allowed. Each company will have to review its practices to determine if they comply with this recommendation or can comply without any significant harm to their normal manner of doing business. I expect that most companies will be able to comply with this recommendation with little difficulty.

The question of implementation of these recommendations will be facing us in the months ahead. A bill HR 8288 was filed last summer by Rep. Barry M. Goldwater, Jr. and former representative Edward I. Koch to amend the Fair Credit Reporting Act and implement some of the recommendations of the Privacy Commission. This bill is not under active consideration now but it is expected that Senator Proxmire will soon file a bill to amend the Fair Credit Reporting Act which will receive serious consideration.

State regulation will also address some of these recommendations and Virginia has already passed a bill relating to notification of adverse underwriting decisions which is similar to the provisions of Recommendations (13), (14) and (15).

The Commission stated that its recommendations were not intended to be specific suggestions for statutory language. However, they are written in a form which permits them to be used in that manner. Thus, it can be expected that many bills will incorporate them with little or no change. Some of their recommendations would present some problems without the explanatory text that accompanied their recommendations.

I believe the industry should cooperate in trying to draft legislation which will be consistent with the objectives of the Commission. We have an obligation to point out problems with suggested legislation and offer alternatives that are workable and not unduly costly to implement. This will be a real challenge, but it is one that the industry is well qualified to handle and I am optimistic about the outcome.

MR. ROBERT S. SEILER: If we take a "geneological" approach to the faces of privacy we see quite clearly that one of the important forebearers was FCRA, the Fair Credit Reporting Act of 1970. FCRA is a "privacy" bill that attempts to exercise some control over informational practices of commercial enterprises, as distinguished from "privacy" as a common law right. The common law "right of privacy" -- or the right to be left alone -- was a form of judicial legislation, in the sense that it had its origins in case law and not in legislation. It was, when established by Justice Brandeis in 1928, new law. However, it grew into protection:

(1) against the appropriation of a person's name or likeness for the user's benefit or advantage;

(2) against invasion of a private place by unreasonable means, that is, the intrusion, without permission, upon a person's physical solitude or seclusion;

(3) against publicity that places the subject in a false light in the public eye; and

(4) against the unwarranted disclosure to the public of facts which are embarrassing to the individual and which adversely affect him.

None of this protection was absolute, and it was designed to compensate one for damages sustained as the result of an invasion of one's privacy.

In contrast, much of modern day privacy legislation is designed to enable one

to exercise prior control over the use of facts about oneself. It depends primarily upon the use of regulatory mechanisms to ensure this informational privacy. It deals with concepts of relevancy, disclosure of intended uses of information, authorizations, prohibitions against additional dissemination and restrictions on information gathering techniques. It establishes penalties which are unrelated to damages sustained and in some of its "faces", it can even subject the "perpetrator" to criminal sanctions.

Looking at some of the other forebearers of today's privacy legislation can give you an appreciation for the development of these new concepts and perhaps an understanding of the pressures for legislation. It should also convince you of the inevitability of some form of additional legislation in this area.

In 1972 the HEW appointed its Secretary's Advisory Committee on Automated Data Systems. The Committee's Report in 1973 recommended legislation controlling informational practices of government, as well as the private sector. It should be noted, however, that the Committee's study did not really look into the impact of its recommendations upon the private sector.

In 1973, the Criminal Justice Act imposed limits on surveillance and eavesdropping practices of governmental agencies primarily.

In 1974, the Buckley Amendments to the Elementary and Secondary Education Act guaranteed student's, and in some cases the parent's, access to school records. If some of you are not allowed to see your children's college grades, you have the Buckley Act to thank. Colleges must obtain the student's consent to release grades, even to parents. Also in 1974, the President's Study Commission on Right to Privacy was established.

Then came the Privacy Act of 1974, which, as originally introduced, was intended to apply to government and private industry alike but, as enacted, was applicable to government data systems only. The compromise created the Federal Privacy Protection Study Commission to study the possible application of the standards contained in the Privacy Act to the private sector. The Privacy Act of 1974 is largely based on the recommendations contained in the HEW Secretary's Report.

During 1975, we saw the introduction of the Goldwater-Koch Bill - HR 1984 - in the Congress. It, too, was based in large measure on the standards for informational privacy contained in the HEW Secretary's Report, as well as some of the concepts contained in the Privacy Act of 1974. We could spend an hour or more enumerating the inadequacies of HR 1984 but, fortunately, events seem to have by-passed HR 1984. If you are interested, the LOMA proceedings of 1975 contain a number of analyses of that Bill.

1975 and 1976 also brought a rash of state legislation using the Privacy Act of 1974 and HR 1984 as models. Over 20 states introduced informational privacy bills applicable to the private sector. Fortunately, none of them passed. We fended them off by pointing to the Federal Privacy Protection Study Commission and arguing that it would be premature to act before the Commission reported. That argument plus the inherent deficiencies in HR 1984 type legislation kept those bills from being enacted. But we merely deferred the legislative pressures.

As you can see, "privacy" is a "hot" item. It has strong political appeal because, as one writer recently observed, it is perceived by the politician as a program that does not cost anything--at least not in the sense of a subsidy or tax. It may not even be directly observable in the prices of goods or services.

That brings us down to the present. We now have the Privacy Commission's Report. That Report covers a wide range of activity in the private sector which I believe accounts for the relative inactivity at the Congressional level in implementing the Report. However, privacy legislation is still with us:

(1) A number of so-called "computer privacy" bills have been introduced at the state level. These are stripped down versions of HR 1984 applied only to computer stored information. In the main they are modeled after an earlier California Bill, AB 150, which calls for the registration of computer systems and certain disclosures. Most of the cost objections to HR 1984 have been eliminated and the bills do not call for a regulatory agency to enforce the law. Instead the courts will determine compliance.

(2) The American Medical Association, the Medical Record Librarians' Association and the Psychiatrists' Association have all developed model bills attempting to establish the boundaries for access to and disclosure of medical information. Generalizing, it can be said that these bills attempt to avoid, or at least shape, one of the tenets of the Privacy Commission's Report, the patient's free access to medical information in the possession of the doctor or medical institution.

(3) Unfortunately, we get swept into some of these bills. Recently the psychiatrists introduced a bill in Illinois which would permit the psychiatrist or therapist to determine what information was relevant in responding to a request for information duly authorized by the patient. It also seeks to limit authorizations to a six month period.

"Telephone privacy" bills have been introduced in Congress. These bills are intended to prevent the so-called nuisance of unsolicited commercial telephone calls. Unfortunately, some of these bills are drafted broadly enough to prevent telephone prospecting by our agents and legitimate policyholder service and conservation efforts by our companies. There are also bills to prohibit the use of computer generated recorded telephone calls. The FCC is also looking at these practices.

(4) At least one state, California, has enacted a statute granting an employe the right to access and correct employment records.

As I mentioned earlier, Congress has been relatively inactive in responding to the Privacy Commission's recommendations. A number of bills have been introduced but none seem to be destined to go anywhere. Congressmen Goldwater and Koch, who were members of the Privacy Commission, introduced a number of bills immediately upon the release of the Report. Those bills

merely incorporated the so-called "black letter" portions of the Report. No attempt was made to incorporate the various exceptions and provisos that are included in the Report. A cynic might say they were trying to capitalize on the publicity value of the Report. It was clear that their bills were destined not to move and have since died.

During the early portion of this session of Congress, Congressman Preyer, at the request of Congressman Goldwater, introduced a single bill HR 10076 again incorporating only the "black letter" portions of the Commission's Report. It was introduced in order to stimulate comment. Oversight hearings on that bill will occur in a couple of weeks. At the moment no real action is expected on that bill or any other comprehensive privacy bill until the fall.

Things are beginning to heat up at the federal level, however. Senator Proxmire, because of his sponsorship of FCRA, is regarded as a logical sponsor of privacy legislation. He also has the "clout" as Chairman to move such a bill through his Banking Committee. The Senator's staff has told us they are working on a bill and we have been expecting it "momentarily" for at least three months now.

The subject of privacy has been of interest to the occupants of the White House. The Ford Administration appointed a Study Commission in 1974 which was, for all practical purposes, supplanted by the Privacy Protection Study Commission which reported both to the Congress and the President. President Carter has established an inter-agency task force in the White House, as part of the Domestic Council, to review the Commission's Report. That task force has been holding a series of brief meetings with affected industry representatives to briefly inform them of their "thinking" on the subject and soliciting comments. Just last week representatives of our trade associations, the MIB and one member company, met with the task force. Current indications are that the Task Force is preparing a draft of a Presidential Review Memo which attempts to draw together all of the Privacy Commission's recommendations, as to all affected industries, into 7 or 8 broad principles. Presumably this would be the basis for a presidential message endorsing those broad principles. However, we have been told that the White House does not intend to introduce omnibus legislation. It may not even introduce any legislation at all, leaving the subject to the normal action of Congress.

The task force, incidentally, was interested in the position of our industry, our comments on the Recommendations, the issue of federal vs. state implementation of the Recommendations and alternative ways to achieve the objectives. All of that in a one-hour meeting.

What is the expected timetable for federal legislation? Because of the way in which Congress is organized, any comprehensive privacy bill seeking to implement the Privacy Commission's Recommendations would be reviewed by several committees of both Houses of Congress. Short of a resolution to consider the bill before each of the Houses as a Committee of the whole (which is not presently regarded as likely), it will be about two years before any final action can be expected. At least that is our current thinking.

How about the states? As you may recall, the Privacy Commission's Recommendations are a blend of federal, state and voluntary efforts to achieve compliance. The Commission itself says that it sought to utilize existing regulatory mechanisms wherever practicable. A number of the Recommendations

(5, 6, 7, 8, 14 & 15) clearly contemplate using the state insurance departments to enforce or implement the recommendations. Others (2, 3, 9, 10, 11, 12 & 13) extend the FCRA, thereby conferring FTC jurisdiction over our insurance operations. The FTC currently regulates our FCRA practices. Recommendations 16 and 17 contemplate the enactment of federal law but do not confer jurisdiction in the FTC.

Last year our trade associations, responding to the Commission's Report urged the NAIC to appoint a Subcommittee or Task Force and an Industry Advisory Committee to review the Commission's Report, and develop appropriate model legislation. The NAIC Task Force was appointed in December and held its first meetings in March to consider industry comments on the Commission's Recommendations. An Advisory Committee, with one consumer representative on it, has also been appointed to assist the NAIC Task Force. The Advisory Committee expects to have some initial NAIC produced drafts of legislation to review and comment upon prior to the June NAIC meeting.

At the moment it appears that Recommendations 1 and 4 (dealing with the relevancy of information and the accuracy, completeness and timeliness of information) will not be the subject of NAIC action. It is not clear what the NAIC Task Force may recommend as respects those portions of the Privacy Commission Recommendations that contemplate federal implementation. Personally, I expect the NAIC to attempt to occupy the field, that being the best tactic to preclude federal incursion into their traditional domain. Commissioner Day of Virginia, who is a member of the NAIC Task Force, has already had a bill enacted in Virginia embodying Commission Recommendations 13, 14 and 15. Recommendation 13, dealing with notices of reasons for adverse underwriting action, in the "black letter" portion suggests amending FCRA as to this item. However, a portion of the text which follows contains an alternative proposal which would implement that Recommendation at the state level, with federal control if the states do not act. Similar alternative treatment is accorded Recommendations 10 through 12 in the Commission's Report.

Final action by the NAIC is scheduled for the December NAIC meeting.

There are a number of other extremely important implications for our industry. Not the least of these is the question of "where will we be regulated?". The Privacy Commission Recommendations, as I mentioned earlier, call for several amendments to the Fair Credit Reporting Act. This automatically injects the FTC further into our business. There is a difference of opinion in the life and health insurance industry as to whether we should oppose those Recommendations which call for FTC enforcement. Those arguing in favor of following the Commission's Recommendations do so for pragmatic reasons. They believe federal legislation is inevitable and that we have a better chance of getting our substantive changes in any bill by supporting the Commission's "objective study". They differentiate between regulation of our information practices at the federal level and regulation of our insurance business at the state level. In addition, they have hopes for more uniformity with federal legislation, even though a number of the Recommendations dealing with forms will be implemented at the state level, thereby exposing us to current experiences with lack of uniformity. Interestingly enough, the casualty industry is opposed to any federal regulation, as are the various agent associations.

I, for one, am opposed to any regulation by the FTC. As to those portions of the Commission Recommendations which are merely amendments to but not extensions of the scope of FCRA, I have no objection to federal regulation. However, Recommendations 2 (pretext interviews) and 10 through 13 (access to and correction of records and notice of reasons for adverse underwriting decisions) are an integral part of our business of insurance. As such they should be regulated by the states. I believe we will get both federal and state regulation in the privacy area if we do not attempt to limit the federal role. Worse yet, given the desire of the FTC to regulate our business, as evidenced by its life cost disclosure investigation, permitting the FTC to regulate our information practices will inevitably lead to federal regulation -- in addition to state regulation. That is neither in the best interests of our policyholders or our companies. The ACLI and HIAA are right now in the process of formulating policy on implementation. Each has agreed to support the substantive recommendations with changes.

Another important implication for our industry grows out of the Commission Recommendations on relevancy (#1) and accuracy, completeness and timeliness of information (#4). Fortunately the Commission did not recommend legislation in either area. Hopefully we will be able to restrict legislative efforts in those areas because relevancy (or propriety) of information is at the heart of our underwriting and pricing functions. We have already seen regulatory and legislative efforts to deprive us of our decision making ability in this area. The regulations on marital status, life-style and sexual preferences are examples of such action, as are bills dealing with the handicapped.

As to requirements for accuracy, completeness and timeliness of information, we would all agree with these as appropriate standards. The question is how much money do we have to spend to ensure a report is not inaccurate? Must we disregard information if we cannot independently verify it? Who determines how complete the information must be? Will we be permitted to use our judgment or will someone else's judgment be used? Who will determine if information is timely - and how? These are all ways of looking at the relevancy of information. Will we be making the decisions or will some government agency? So long as we continue to function with the best interests of the public and our policyholders in mind we should be able to reserve these judgments to ourselves. There will, of course, be some situations where government will be asked to determine if some information is socially permissible. But that should be a legislative determination, not a regulatory decision.

Privacy undoubtedly means change for our business. If we keep the subject in perspective and work to shape the legislation, we have nothing to lose, and everything to gain, by supporting the basic principles underlying the Commission Recommendations. If we do that we can afford to differ with legislative proponents on the details of the recommendations and how the legislation will be implemented.

MR. CHARLES N. WALKER: You talked about Recommendation (1) not turning up as legislation, but was not that matter referred to the NAIC Complaint Task Force with expectations that they would develop a new complaint category for dealing with relevance?

MR. SEILER: Yes. The Privacy Commission says there should be a mechanism

to collect complaints to determine whether or not information that is being collected is either proper or relevant. We say the mechanism is in place for our industry and the insurance department, and through the insurance departments we say that you already have the model complaint recordkeeping regulation which is designed to enable you to collect this information. At this session of the NAIC they will probably develop another category for your recordkeeping so you will have one which deals with relevancy of underwriting information.

MR. ROBERT B. SHAPLAND: Is there any work afoot in the Society of Actuaries or elsewhere to enable health companies, for example, to pool their impaired experience to get creditable data?

MRS. EMORY: I know health is an area where we do not have the statistics we have in life because we have not been doing the rating and so forth for as long. There is a new life impairment study underway.

MRS. BARBARA J. LAUTZENHEISER: The industry is writing more and more non-medical in all areas because it is so costly to get the information. Yet the states and the federal government are requiring substantial and significant data. It is very important that we start doing more research.

MR. SEILER: We made the argument before the Privacy Protection Study Commission that you can not cut off our ability to collect information because if you do, we have no way of differentiating between the risks, and no way of giving to those people who deserve better rates. They seemed to understand what we were saying and I do not believe they really cut us off from that in the Privacy Commission Reports. When we face these issues at the state legislature and perhaps at the federal level, we ought to be able to rely on the Privacy Protection Study Commission Report in that very area. We ought to be doing a better job of explaining to our policyholders just how we do rate and why we differentiate between risks because that is the real heart of this whole issue. It is going to be a political and emotional issue. If we cannot explain why we are doing things and why it is to the advantage of people to let us continue to do some of the things that we are doing from an underwriting standpoint, we deserve to lose the underwriting skills that we are now exercising.

MR. KARSTEN: If underwriting judgment says a proper evaluation cannot really be put on that risk, the traditional role of the underwriter has been to say "I decline to insure that risk". The applicant is perfectly free to go to any other company where an underwriter may feel he does have the judgment to properly assess that risk. As long as we have voluntary life insurance, all the statistics in the world are not going to cover every situation. I think the element of mandatory coverage can lose this traditional freedom of voluntary life insurance.

MR. DANIEL F. CASE: We can not be expected to have data to cover every applicant. There must always be a place for judgment. The laws and regulations that we are beginning to see will apparently require data at least for impairments for which one might reasonably expect that creditable data could be collected. What can we do that we are not doing now to assemble the data that companies sometimes have individually, but which are not creditable in the volume in which individual companies have them? When there was a hearing in Missouri recently on a proposed regulation on blindness, for

example, the Missouri Director of Insurance asked us to submit to him whatever data we could on blindness. We found that a few companies did have data which bordered on the credible, or in one case which the company itself characterized as being statistically significant at the 95% confidence level, but there was another company that had slightly less significant data and was hesitant to share it and to actually have it submitted to the Missouri Director as coming from an individual company. Is there some way, short of doing a full-blown medical impairment study which is being done now but which is not going to cover every impairment because it just cannot and because it is too expensive, to assemble and collate individual company results to obtain more creditable results?

MR. WALKER: Yes. The Joint Committee of the Society of Actuaries and Life Insurance Medical Directors produced a Build and Blood Pressure Study and one on atrial fibrillation is in progress. But as you properly point out, that is a very long and slow process. I would also note for you the publication of "Medical Risks: Patterns of Mortality and Survival", which collected a great deal of insured life information, and also collected a great deal of clinical information and put it into mortality study form. Even though much of it is not on insured lives, it still amply demonstrates differentials in mortality.

MR. KARSTEN: The most complete and credible statistics I have ever seen is the Build and Blood Pressure Study. The Study was completed just before blood pressure treatments became popular, so the study was outdated immediately. For untreated blood pressures there is nothing more statistically significant in my mind than what has been published. There is a great deal of variance in the use of those credible statistics. Underwriting judgment is used with them. Now how do you rationalize this to the present legislative thrust? Should all companies be forced to underwrite at the same level, to offer the same risk classifications? I think there are deeper questions, even if we do accumulate more statistics, than some of the less frequent areas of underwriting problems.