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**INDIVIDUAL RISK CLASSIFICATION—UNFAIR  
DISCRIMINATION & PRIVACY**

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1. Legislation and regulations restricting selection criteria
  - a. Industry response
  - b. Development of statistical data
  - c. Applicability of clinical opinion and research
2. Privacy Commission recommendations and subsequent legislation
  - a. Industry response - disclosure, pre-notice, etc.
  - b. Effect on availability of underwriting information
  - c. Impact on pricing - increased administration costs, morbidity, etc.

MR. HARRY A. WOODMAN, JR.: Our panel today will deal with two subjects that are currently very important to actuaries associated with the administration and results of individual risk classification. The first subject deals with legislation and regulations restricting selection criteria. The second subject deals with the Privacy Commission recommendations and subsequent legislation.

It is clear that we have problems in these areas of discrimination and privacy that have been brought about and intensified largely by misconception and misunderstanding. We have many persons in our industry, not the least of whom are our panelists, who continue to work hard to maintain a dialogue with legislators, regulators and consumers so that they will understand our needs. Through their efforts, we hope that legislation can be shaped which will enable us to continue to discriminate fairly and to invade privacy when we "need to know," subject to proper disclosure to and about our sources and actions.

Because, on balance, we feel we have done a reasonably good job in achieving equity and protecting privacy, some of us have tended to react adversely against criticism from those who do not fully understand the way our business works. However, those who have listened to our critics have been able to learn and have realized that some of our ways of doing business, particularly our communications, could be improved.

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MR. EDWIN T. HOLMES: Interest and activity in governmental regulation of insurance risk classification is rapidly increasing. As of October 25, 1978, there were 31 state risk classification laws and regulations which affect life and health insurance. By March 31, 1979, there were 49 reported pending bills on life and health insurance risk classification -- 3 in the United States Congress and 46 in state legislatures. Significant risk classification issues - notably maternity issues - have recently been litigated in state and Federal courts. In addition to growing state insurance department scrutiny of the life and health insurance industry's underwriting practices, the attention of Federal agencies has focused on alleged unfair discrimination by life and health insurers because of the sex of applicants and insureds. Moreover, the National Association of Insurance Commissioners has been most actively studying alleged unfair discrimination by insurers on the basis of blindness and mental and physical impairments, as well as the desirability of mandating unisex rates and maternity coverage in accident and health insurance.

The March 1972 approval by the United States Congress of the proposed Equal Rights Amendment to the United States Constitution was a major factor influencing the development of interest in life and health insurance risk classification. However, Equal Rights Amendment activity does not stand alone as such a historical and social backdrop. Certainly the civil rights movement of the 1960s engendered broad political, legislative and judicial interest in notions of equality and refined the concept of equal protection of the law. Furthermore, as one insurance executive has noted, the current interest in discrimination in insurance is related to the concept of egalitarianism. In the Senate Report to the District of Columbia White Cane Law, the concerns of handicapped persons were put eloquently:

...a blind person, a legless or armless, or deaf person, has the same right to live in the world, to work and travel and function in all ways just as the physically fit live and work, and travel and function, free from myth-based limitations or unreasoned or unreasonable attitudes and practices -- practices that diminish or deny the disabled person rights innately his as a person and as an American citizen.

These concerns have resulted in the following recent governmental action and industry response regarding risk classification.

It is appropriate to survey first a number of developments in sex discrimination, because substantial insurance regulatory interest in sex discrimination has recently preceded regulation of other risk classification areas.

#### A. NAIC Model Sex Discrimination Regulation

The NAIC adopted a model sex discrimination regulation in 1976. The purpose of this regulation is to eliminate sex discrimination in the marketing and underwriting practices of insurance carriers. The regulation provides that: The availability of any insurance contract shall not be denied to an insured or prospective insured on the basis of sex or marital status, and that the amount of benefits payable or terms, conditions or type of coverage shall not in any way be restricted on the basis of sex or marital status - except that there may be variations as a result of rate differentials permitted by statute. Marital status may be taken into account for the purpose of defining persons eligible for dependents' benefits. Examples of prohibited practices are specifically set forth in the regulation.

Sixteen states have adopted sex discrimination regulations similar to the NAIC model. Most major insurers doing business nationwide have modified their practices in accordance with the regulation even in the remaining states. For example, a recent study by Paul Barnhart, FSA, and current president of the Society of Actuaries, demonstrates that not only do none of the 31 major individual disability writers follow any sex discriminatory practice prohibited by any state, but in virtually every instance these companies voluntarily follow non-discriminatory practices even in those states that do not prohibit discriminatory practices.

The standard source of authority for a state sex discrimination regulation is the state's unfair trade practices act. State unfair trade practices acts are generally based on the NAIC Model Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance. Section 4(7) of the model act, a version of which is the law in practically every state, prohibits unfair discrimination between individuals of the same class and equal expectation of life in the rates charged in any life and health insurance or annuity contract or the terms or conditions of such contract. Unfair discrimination is also prohibited in Section 4(7) between individuals of the same class and essentially the same hazard as to rates charged for any policy or the benefits or terms or conditions of the contract or in any other matter.

#### B. State Maternity Laws And Regulations

A number of states have enacted statutes and promulgated regulations concerning health insurance benefits for pregnancy and maternity. These laws may be classified as follows: a) statutes mandating coverage for normal pregnancy; b) statutes mandating coverage for complications of pregnancy; c) statutes mandating maternity coverage regardless of marital and dependency status; and d) statutes mandating the availability of maternity benefits. There are two types of state regulations dealing with maternity: a) those similar to the NAIC model sex discrimination regulation described above; and b) a variety of regulations on different subjects such as complications of pregnancy, sex and marital status discrimination regulations, minimum standards and group replacement.

#### C. Maternity Cases

Both federal and state courts have dealt with assertions that denial of pregnancy and maternity benefits to females violates guarantees of equal protection under the United States and state constitutions and statutory guarantees of equal employment opportunity.

##### 1. HIAA v. Harnett - Mandatory Hospital, Surgical or Medical Coverage

In HIAA v. Harnett, decided by the New York Court of Appeals on May 2, 1978, the Court decided that the New York statute mandating the inclusion of maternity care in health insurance policies did not deprive insurers of property without substantial due process of law. Sections 162-a, 164-a and 253 of the New York Insurance Law requires that health policies which provide hospital, surgical or medical coverage shall provide coverage for maternity care, including hospital, surgical or medical care, to the same extent that coverage is provided for illness or disease under the policy. Plaintiffs alleged that they were denied due process because they were being required to sell a type

of coverage they may not want to sell, and which buyers may not want to buy, at additional cost. Plaintiffs claimed therefore that insurers would be deprived of substantial revenue because purchasers would be unwilling to buy at the increased cost. The court was of the opinion that the statute did not violate constitutional due process and was a valid exercise of the state's police power. The court also held that the law cannot be applied to policies in existence before January 1, 1977, which may be renewed at the sole option of the policyholder.

## 2. General Electric Co. v. Gilbert - Group Disability Benefit Plans

Several notable cases have recently dealt with the issue of pregnancy exclusions in group disability benefit plans. The holding by the United States Supreme Court in the Gilbert case that it was not sex discrimination under Title VII for employers to exclude maternity benefits from disability insurance plans was in contrast to decisions by state courts, interpreting state Civil Rights laws with language identical or similar to Title VII and state labor laws, that such failure by employers would indeed constitute sex discrimination. The majority of states require that employers treat maternity disabilities the same as other temporary disabilities in relation to insurance and sick leave.

The United States Supreme Court in General Electric Co. v. Gilbert, held that an employer's group disability benefits plan does not violate Title VII of the Civil Rights Act of 1964 because it does not cover pregnancy-related disabilities. In that case the majority in a 6 to 3 decision stated that General Electric's disability benefits plan did not exclude anyone because of sex, "but merely removes one physical condition -- pregnancy -- from the list of compensable disabilities."

In Nashville Gas Co. v. Satty, a policy of denial of sick leave to pay pregnant females was found by the U.S. Supreme Court to be legally similar to the disability benefits plan at issue in Gilbert.

## 3. State Maternity Cases

However, four state courts have arrived at conclusions different from those of the U.S. Supreme Court. The New York Court of Appeals in Brooklyn Union Gas Co. v. New York State Human Rights Appeal Board held that the New York State Human Rights Law overrides the pregnancy exclusion of the disability benefits required to be provided by private employers under 205(3) of the New York Disability Benefits Law. The Wisconsin Supreme Court, in Ray-O-Vac. Div. v. Wisconsin Department of Indus. Labor and Human Relations found that the statutory prohibition against discrimination in employment is a more specific command than that of the Fourteenth Amendment in striking down pregnancy benefit exclusions or limitations, and that pregnancy is undeniably a sex-related characteristic.

In Massachusetts Electric Co. v. Massachusetts Commission Against Discrimination the Massachusetts Supreme Judicial Court has upheld a finding by the Massachusetts Commission Against Discrimination that the exclusion of temporary disabilities related to pregnancy from a comprehensive disability plan constituted unlawful sex discrimination. In Anderson v. Upper Bucks County Area Vocational Technical School, the Pennsylvania Commonwealth Court affirmed a decision by the Pennsylvania Human Relations Commission that the Pennsylvania Human Relations Act required a school to grant credit against accumulated

sick leave to a teacher who was absent from the job as a result of her pregnancy. The court stated "that since pregnancy is unique to women, a disability plan which expressly denies benefits for disability arising out of pregnancy is one which discriminates against women employees because of their sex."

At least one state attorney general has issued an opinion similar to the holdings in the state court disability cases. On June 8, 1978, the Vermont Attorney General's Division rendered an opinion that pregnancy-related benefits should be treated in the same manner as any temporary illness.

#### 4. Human Rights Commission Actions

An increasing number of actions are being filed by or with state or local human rights commissions against insurance companies, based on a complaint of sex discrimination, usually related to employee benefit plans. State or human rights commissions for the purpose of this discussion include: state human rights commissions, such as the New York State Executive Department Division of Human Rights; fair employment practices agencies with discrimination jurisdiction, such as the Massachusetts Commission Against Discrimination, and the Wisconsin Division of Industry, Labor and Human Relations; and municipal agencies, such as the Bloomington, Indiana Human Rights Commission.

These commissions often assert that, through the sale of group insurance contracts to employers, insurers aid and abet or are the agents of the employer. Also these commissions often allege that group insurers are selling insurance contracts which are public accommodations and thus practicing sex discrimination by excluding coverage for, among other things, expenses related to normal pregnancy. It is difficult, if not impossible, to keep track of state or local human rights division actions involving insurers, most of which are not reported.

#### D. NAIC Sex Discrimination Study

In June 1978, the NAIC Task Force on Sex Discrimination of the Accident and Health (C1) Subcommittee proposed the following amendments to the NAIC Model Regulation to Eliminate Unfair Sex Discrimination for consideration and study: 1) The promulgation of a new model regulation to abolish the use of sex and marital status as factors in determining rates in accident and health insurance; 2) The modification of the current model regulation on unfair sex discrimination to provide full maternity coverage versus only coverage for complications of pregnancy; and, 3) The review of the current status of those states that have adopted the NAIC model regulation.

The NAIC Task Force held a public hearing on the proposed amendments in New York City on November 13, 1978, at which representatives of Health Insurance Association of America and American Council of Life Insurance testified at length. HIAA and ACLI made the following points: First, there is no statutory authority either in the NAIC Model Unfair Trade Practices Act, or elsewhere in the state law, on which to base an administrative regulation mandating either maternity coverage or unisex rates. Second, for practical purposes the passage by Congress and signing into law by the President of PL 95-555, the Pregnancy Discrimination Act, essentially moots the question of mandating maternity coverage by regulation. Third, the unfairness of mandating insurers to provide maternity coverage applies most heavily to the forms of coverage left unaffected by PL 95-555 -- that is, individual policies and small group policies.

Fourth, to prohibit sex-based rating differentials, even by statute, would unfairly limit the ability of insurers to classify insureds equitably and would result in the failure of many persons to buy health insurance.

The most negative impact of the proposals under consideration by the NAIC Task Force for unisex rates and to mandate maternity benefits would be felt by individual disability income insurance, a line of business already overburdened by regulation and business problems. The unisex proposal would also repudiate the well-considered conclusions of the New York Insurance Department Study on Disability Income Insurance Cost Differentials Between Men and Women, published in June 1976, and the implementing regulation of the New York Department based on this study.

On December 5, 1978, during the NAIC meeting in Las Vegas, Nevada, the task force submitted an interim report to the Accident and Health (C1) Subcommittee. The report made a series of findings which question or dispute the industry's claims as to adverse selection and over-pricing of insurance if unisex rates and mandatory maternity coverage were adopted. The report indicated assumed discrepancies between industry statistics on health insurance losses for women as compared to those for men and studies by agencies such as Social Security. As subsequently modified and adopted, the task force report asked the industry for additional statistics on disability health insurance for women and to reconcile these statistics with those shown in certain non-industry studies by April 1, 1979.

On February 26, 1979, a letter from Barry M. Clause of the North Carolina Insurance Department on behalf of the NAIC Task Force on Sex Discrimination submitted the following questions to the industry, noting that this list represents the essence of the basic issues listed by the task force at the hearing held on November 13, 1978 and again at the December 1979 NAIC meeting in Las Vegas as set forth in the task force report adopted at that meeting:

1. Evidence submitted to the Task Force demonstrates disparate experience in disability expenses for women, some showing a higher expense for women than men, and others showing the reverse. A common basis for computation is required to allow comparison of data among the various groups.
2. The assertion is made that women have higher health care costs than men. Competent data derived by a common basis of computation is required to support this assertion. This data should be reconciled with the fact that women do not use significantly more sick days than men. Further, account must be taken of the fact that an initial medical opinion of a given condition and requiring surgery is negated with significant frequency by a second medical opinion that surgery is not required.
3. What would be the incremental cost increase for health insurance for the whole population: (1) If the cost of maternity would be spread over the whole insured population; (2) If the cost were spread over the population of men and women of child-bearing age; and (3) If the cost were borne only by women, married and unmarried of child-bearing age.

4. State the rationale for retaining sex-based data in accident, health and disability insurance, when it is being abolished in automobile insurance.

The answer to question 4, regarding the rationale for retaining sex-based data in accident, health and disability insurance, had been stated in detail by HIAA and ACLI to the task force at the November 13th hearing mentioned above. However, Mr. Clause's questions 1-3 were dealt with in detail in a lengthy actuarial paper presented by HIAA/ACLI to the Task Force on April 9, 1979 at the Zone II meeting in Wilmington, Delaware. This analysis and interpretation of statistical data was prepared by actuaries of HIAA and ACLI, Peter Thexton and Daniel Case, working under the supervision of five company actuaries. Their general conclusions were these:

In the judgement of the actuaries preparing this paper, the evidence is overwhelming that disability and medical expense claim costs are different between males and females. Age, sex and occupation are the primary parameters on which health insurance rates are based and which are examined herein. We observe a definite and consistent pattern in the ratio of female to male claim costs, varying substantially by age but little by occupation, in both insured and non-insured data, over long periods of time. The pattern is that female claim costs are higher at the younger ages and lower at the older ages. The pattern is consistent within and between disability and medical expense experience.

Furthermore, the evidence suggests convincingly that the magnitude of the differences between male and female claim costs is sufficiently large that unisex rates would be unfairly discriminatory against the less favored classes, younger males and older females. The more closely occupation is controlled, the larger are the observed differences and the more unfair would be the discrimination from a unisex mandate.

Finally, mandatory cost-spreading devices as to maternity would also be unfairly discriminatory against unmarried and older males and females. Young married males bear a full share of the cost to the couple, regardless of the rate structure. Others should not have to share this cost.

No mandate will change the facts of claim cost differences. People in general are aware of these facts and act in their own self-interest in relation to them. In particular, people will endeavor to defeat cost-spreading, if they can save some money. The experience of the assessment societies is so well-known and so clear that we need only mention it, not describe it.

Apparently unpersuaded by the evidence submitted to it so far, the NAIC Task Force has requested further information which is being supplied by HIAA and ACLI. It is expected that no definitive action will be taken by the NAIC on these issues at the June 1979 meeting. Instead, on-going discussions between the task force and industry will probably continue until the December 1979 NAIC meeting.

In addition to its broad sex discrimination study, the NAIC has also been actively studying allegations of unfair discrimination against the blind and the physically and mentally handicapped.

#### A. NAIC Blindness Study

During the NAIC meeting in December 1977, the NAIC (BI) Subcommittee on Unfair Trade Practices established a task force and advisory committee to investigate the existence of unfair discrimination against the blind by insurers and the need for a model regulation prohibiting such practices. In its report submitted at the June 1978 NAIC meeting, the task force concluded that unfair discrimination against the blind does exist in the rating of and refusal to insure blind applicants. This conclusion was based on four sources of information: (1) a survey of state statutes and regulations indicating unfair discrimination; (2) examples of alleged unfair discrimination from the National Federation of the Blind; (3) a completed questionnaire from the Advisory Committee member companies on relevant underwriting practices; and (4) information from each of the states of the Task Force members.

In June 1978 the NAIC adopted a model regulation dealing with unfair discrimination on the basis of blindness or partial blindness, which the task force had drafted. The regulation prohibits any discrimination in coverage or rates unless it is based "on sound actuarial principles" or is related to actual or reasonably anticipated experience.

#### B. NAIC Handicap Study

At the June 1978 NAIC meeting, the NAIC (BI) Subcommittee on Unfair Trade Practices decided to expand the investigation of unfair discrimination to "handicap, physical or mental condition" other than blindness. An NAIC task force and advisory committee was directed to study this question and draft any necessary law or regulation. The chairman of the task force has requested that the advisory committee, which represents not only the life and health industry but also the property and casualty industry, conduct a survey of underwriting practices regarding the physically and mentally handicapped.

In addition, this NAIC investigation has caused the life and health insurance industry to examine and clarify its practices and policy on underwriting physically and mentally handicapped risks. In September 1977 the HIAA Joint Risk Classification Subcommittee and the ACLI Subcommittee on Risk Classification drafted a proposed model risk classification bill or regulation.

In the course of drafting such a model bill, the principal purposes of fair classification in individual life and health insurance were reaffirmed as being: (1) to assure equity among insureds; (2) to maintain freedom of choice by the consumer in a competitive marketplace; and (3) to provide insurance through a solvent private insurance system. After further refinement, the proposed model regulation on unfair discrimination on the basis of physical or mental impairment is designed for promulgation under Section 4(7) of the NAIC Model Unfair Trade Practices Act. Subsection 4(7)(a) prohibits "any unfair discrimination between individuals of the same class and equal expectation of life in...any contract of life insurance or of life annuity..." and Subsection 4(7)(b) prohibits "any unfair discrimination between individuals of the same class and essentially the same hazard...in any policy or contract of health insurance..."



The main purpose of the proposed model regulation is to make clear that insurers cannot classify applicants for insurance arbitrarily or without a rational basis for each decision. The proposed regulation indicates the foundation for a rational basis by stating that any classification must be "based on sound actuarial principles or related to actual or reasonable anticipation."

On March 29, 1978 the proposed model regulation was submitted to the NAIC task force which adopted it after making several amendments. Drafting notes are now being prepared by the Industry Advisory Committee to the task force which will accompany the proposed regulation. The NAIC is expected to take action on both the regulation and the drafting notes at the June 1979 NAIC meeting.

From the brief survey of governmental regulation of risk classification stated in the preceding sections of this paper, it is clear that governmental interest in the underwriting practices of health insurers is increasing. Such interest to date has been expressed in a variety of ways. State legislatures are considering numerous legislative proposals and have already enacted a substantial body of law in the risk classification field - especially regarding maternity coverage. Sixteen state insurance departments have adopted the NAIC sex discrimination regulation and other state insurance departments are considering taking similar action. State and Federal courts have scrutinized underwriting practices in a number of cases on maternity coverage. Not only has other risk classification litigation occurred, but more litigation is now pending and new cases can be expected. In addition, the NAIC has studied and drafted regulations concerning blindness and handicap. Moreover, the NAIC is currently studying the desirability of mandatory unisex rates in health insurance.

The private health insurance industry has responded to these developments by taking the following action. Most major insurers doing business nationwide have modified their underwriting practices in accordance with the NAIC model sex discrimination regulation. Moreover, the private health insurance industry has examined and clarified its practices and policy on underwriting physically and mentally handicapped risks. In the course of drafting a model bill or regulation on risk classification, the principal purposes of fair classification in individual health insurance were reaffirmed as being: (1) to assure equity among insureds; (2) to maintain freedom of choice by the consumer in a competitive marketplace; and (3) to provide insurance through a solvent private insurance system. Finally, this industry has cooperated with and contributed its considerable expertise to the NAIC, to state insurance departments, to state and federal courts and legislatures, as well as to consumer groups, in order to assist in the equitable resolution of risk classification issues.

DR. JACK A. END: It is a pleasure to be invited to participate in your meeting, and I have enjoyed the meeting, the people, and the spectacular scenery.

I believe it is pretty well agreed that the attack on the risk classification process is the most serious problem currently facing the insurance industry in view of the potential long term effects. One of the factors contributing to the problem is the semantics involved, and the use of the term "discrimination" is unfortunate since many people think of it in its common usage which has connotations of prejudicial bias against individuals or groups. What we have to do is educate people that by discrimination we are following

a reasonable, logical process essential to our business by distinguishing or differentiating between groups by evaluating various criteria. It is obvious that we all support elimination of unfair and unjustified discrimination by the use of arbitrary and unjustified pricing differences.

The whole legislative, regulatory and consumerist or special interest movement toward mandated underwriting seems to follow along with changes in our personal values and social attitudes. There is an increasing espousment of the philosophy of entitlement in which everyone is deemed to have a right to whatever anyone else has, while the equality concept seems to have supplanted equity in the minds of many people who do not realize that it is essential for insurance companies to charge appropriately different premium rates to classes of insurables having significantly different probabilities of loss if we are to be fair and equitable to all. Each class must bear its fair share of the risk probabilities or the whole distribution of risk is thrown out of kilter. If equal premium rates are established for classes having significantly different probabilities of loss, the poorer risks have a greater incentive to purchase the insurance, the better risks less so. The increased claims resulting from this disproportionate group inevitably results in premium increases, which further discourages the individuals with lower probability of loss from joining the class. This voluntary private mechanism is thus limited in the extent to which it could accomplish broad social purposes. There is an obvious difference between a voluntary private mechanism and a Federal or state subsidized mandated program which disregards significant cost differences.

We do not seem to be experiencing as much trouble with regulatory demands for mandated underwriting standards and/or evidence supporting our action as we anticipated a few years ago, and it may be that our scare was premature and we were tilting with windmills. However, realistically it is well for us to be concerned and plan our strategy and work up our data carefully realizing that this is probably a "camel getting his nose under the tent" movement which will gain momentum.

To date many of the impairments in which mandated underwriting was stimulated by special interest groups were already being handled favorably by most of the companies, and some of the impairments occur so infrequently that there was no problem. The biggest problems seem to be the "wastebasket" categories such as "impaired risk," "mentally or physically handicapped," etc., in which there is no clear cut listing of the actual impairments. To satisfy the Kansas Department requirements of reporting our actual handling of cases of "severe disability," we run an EDP ASSIST program on 21 codes that we believe fulfill the criteria of a "severe disability."

The whole subject of credible statistics supporting underwriting practices is a sensitive one. Certainly data is not available for all situations since many impairments occur so infrequently that even pooled inter-company studies would not develop enough cases for a valid statistical study. There are all the other problems such as the difficulty in identifying and isolating the impairment, the fact that for insurance statistics we would not have anything on cases that had been declined, the lag interval before we could evaluate the effect of newly developed techniques of treatment, and the fact that changing circumstances may make prior data not relevant (the change of tar and nicotine content of cigarettes). Those of us in the selection end of the business find it a little degrading to think that there should be a requirement that credible data be available to support all underwriting dis-

tinctions. Experienced underwriters are capable of making sound, logical decisions based on experience, general knowledge, clinical experience and comparison to impairments with comparable risk.

The insurance industry has always been cognizant of the desirability of assuring fair and equitable treatment of all applicants and over the years has made strong efforts to develop sound mortality experience as a basis for establishing or liberalizing underwriting rules:

- A. Many joint impairment studies going back to the turn of the century.
- B. The impressive 1959 Build and Blood Pressure Study.
- C. The current Build and Blood Pressure Study to be published in two volumes in late 1979 and early 1980. You have all seen the preliminary results on the bulletin board outside the room, which have been furnished to the media in a press kit.
- D. Volume I of Medical Risks, Patterns of Mortality and Survival.
- E. An Ad Hoc Mortality Monograph Committee under the moderator of this panel, Mr. Harry Woodman, is working to prepare Volume II of Medical Risks.
- F. The recently completed Atrial Fibrillation Study which was completed as a model for studies of impairments with relatively small numbers of entrants, using the facilities of the Medical Information Bureau Center for Medico-Actuarial Studies. A paper is currently being prepared for publication in a clinical journal.
- G. Association of Life Insurance Medical Directors of America has conducted five seminars with representatives of the American Hospital Association on congenital heart disease, coronary heart disease and hypertension. The most recent was held in October 1977, and a paper is currently being prepared for publication in a clinical journal. There have also been two seminars with the American Diabetes Association and one with the American Medical Association preceding its clinical meeting. All of these function to keep our knowledge up to date with the best available current thought, as well as reciprocal education of the clinical participants regarding the insurability problem.
- H. To enable individuals to prepare and evaluate clinical studies, with conversion of their data to life table format, four mortality abstract seminars have been conducted by ALIMDA, and two or three a year are scheduled in convenient geographical locations. These are available for ALIMDA members, and if openings exist, for interested actuaries and underwriters. The next seminar is to be held in New York in November.
- I. ALIMDA maintains a repository of responses prepared for regulatory bodies on some impairments, and four companies maintain a subject file of good clinical articles. Both of these projects should aid companies in doing research to enable them to evaluate the soundness of their practice or to justify their decisions.

- J. The published proceedings and transactions of ALIMDA, the Medical Section of ACLI, Home Office Life Underwriters Association, Society of Actuaries, the Institute of Home Office Underwriters, the American Academy of Actuaries, etc., all contain reports of studies on various impairments made by individual companies.

There are also some programs pending now which will be productive in the future:

- A. To make mortality data retrieval for intercompany studies more efficient and thus facilitate the performance of studies, we are discussing with MIB the revision of Appendix B which is used for internal coding of impairments. This system has fallen into disuse, and since it is not used by enough companies, and since the impairments are too general and too few to be of much use for studies, we hope to institute a separate file within the MIB which will be used only for research purposes with the contents not furnished to other members.
- B. An Ad Hoc Committee on Smoking of the Liaison Committee is being formed currently. In this area I think we lack credibility, since many companies do not include any questions on smoking habits, and other than the preferred risk concept, many companies disregard smoking as a risk factor despite it having probably more significance than some other risk factors that we classify. This committee will consider the feasibility of an industry study, recommend that companies consider including the smoking questions on their forms, code the information so studies can be made and encourage any companies who have studied their experience to make their data available.
- C. I have recommended to Dan Case, actuary of ACLI, that he consider establishing a repository of the testimony given at various state hearings on impairments by ACLI, HIAA, and locally domiciled and/or interested companies. Many of these are fine position papers which could be helpful to companies in other states who may be confronted with a similar situation.
- D. We are currently investigating the feasibility of establishing a relationship with the Mayo Clinic to utilize their extensive medical records for research studies of some impairments.

So, what should we do as responsible members of the insurance industry?

1. Some companies have established an Underwriting Trends Committee with representatives of Medical, Actuarial, Law and Underwriting Departments, to attempt to stay on top of any legislative, regulatory or special interest group activity in your state so that you can promptly become active in collecting and presenting evidence that will be helpful.
2. Suggest that a company task force prepare and circulate a "Statement of Objectives" which may be helpful in refuting many of the charges about the insurance industry made by irresponsible individuals both within and outside the industry.

3. Make an aggressive effort to educate on the need for risk classification as many groups as possible -- the regulatory authorities, the legislators, special interest groups, our own home office people, our field force and the public at large. The last is a big order, and I don't know exactly how to accomplish that. The Liaison Committee is in the process of appointing an Ad Hoc Committee on Public Education on Risk Classification, and hopefully articles can be prepared for the popular press and speaking engagements can be stimulated. Perhaps a well-oriented field force could plant a few ideas with their clients at the point of sale. Consideration should be given to the use of informational stuffers enclosed with premium notices.

In any event, it must be apparent that risk classification is vital to our remaining a sound, healthy, private voluntary business.

MR. ROBERT B. SHAPLAND: Without risk classification we say that we cannot survive. How do we go about proving that?

We see advertisements that we can buy life insurance at any age with no health questions asked. Mutual of Omaha sells cancer insurance with the same premiums at all ages. Has the industry done anything about trying to prove the contention that we cannot survive if we are forced to give up risk classification?

MR. WOODMAN: We have evidence in mortality statistics that most people tend to select against insurance companies if the same rate is offered to all. Those who are impaired will be more likely to purchase such coverage and do so in larger amounts than those who are not impaired. Risk classification is needed to control this anti-selection.

MR. GARY L. CORLISS: I am not aware that anybody is making a big effort in this area. However, I think people could easily use our own history against us and argue that we will not go down the tubes with these changes. Just review our own past. At one time, we would not insure black people because they had higher mortality. Orientals were not considered desirable either because of a tendency to return to their homelands. Later, we were forced to change and we have survived. We are still surviving with the changes that are going on now such as mandated coverages. We just need to review and react to changes one at a time.

MR. ALAN N. FERGUSON: I may be a little heretical when I say that I think we can live with unisex rates. Now, this might require that each insurance company should have a fair proportion of males and females and if you think about this you might decide that the cure is worse than the disease. I think, however, that with disability income and with medical insurance we could possibly live with unisex rates. I am not as sanguine about living with mandatory maternity because that is a real invitation to anti-selection. A young woman who plans to get pregnant and then buys a policy for \$300 is getting a terrific buy when you consider that the cost of a maternity stay in New York is something like \$2,000.

MR. GARY CORLISS: It could be said the Privacy Issue was born in 1972 by the events surrounding Watergate. The post Watergate mood in the United States caused Congress to become very sensitive about the abuse of personal information. Congressmen Barry Goldwater, Jr., and Edward Koch proposed a Privacy Bill named H. R. 1984. As a result of this bill, Congress passed the Federal Privacy Act of 1974 which imposed restrictions on how the Federal government could acquire, use and disclose the information it collects.

Until almost the twelfth hour, it appeared that private industry would also be covered by this 1974 Act. In removing the private sector from coverage of the direct act, the law made provision for a Presidential Privacy Protection Study Commission. The commission members were appointed by President Ford in 1975. The purpose of this seven member Commission was to study the impact of the legislation on government as well as its impact if the law were extended to business.

After over two years of public hearings and research, the commission issued its recommendations during the summer of 1977. The commission concluded that a balance had to be struck between the interests of those people who need and keep records and those on whom the records were being kept. In attempting to balance these competing interests, they were guided by three objectives:

1. To minimize intrusiveness by constraining what an individual is expected to divulge about himself or is asked to permit others to divulge about him, when seeking a service or benefit.
2. To maximize fairness by creating incentives for organizations to manage their records about individuals so that they will not become a source of unfairness in any decision based on them.
3. To create enforceable expectations of confidentiality.

Within this framework, the commission had to determine how to protect individual privacy interests without overburdening business or government with restrictions on the flow of personal information essential to the equitable treatment of individuals.

The commission considered and rejected the approach taken by the Privacy Act of 1974 which imposed a single set of requirements on all Federal government agencies. The commission's recommendations take into account the special circumstances of each major type of recordkeeping relationship. Information practices were examined separately as they related to consumer credit, banking, insurance, employment, medical care and education. Different rules were suggested for each area.

The commission also tried to build on existing statutory and regulatory systems, particularly the Fair Credit Reporting Act and state insurance department regulation. Lastly, the commission wanted to allow room for voluntary compliance wherever possible.

A more practical explanation of the commission's objective was to:

1. Open to public scrutiny the recordkeeping practices of both the private and government sectors.
2. Reveal how recordkeeping mechanisms work.
3. Give individuals the right to learn what information is kept about them.
4. Provide them with the opportunity to correct erroneous information.

The thrust then was for recommendations that would constitute a positive force which would dispell the skepticism about the motives and practices of private institutions.

In the insurance field specifically, it seemed that the reason the industry was often suspected of invading an applicant's personal privacy was that the recordkeeping activities and decision making processes were not understood by the public. This misunderstanding is compounded by the fact that the total insurance industry probably gathers more personal information about individuals than any other part of the public or private sector. Is it any wonder then that the Privacy Commission felt compelled to make some recommendations concerning activities of the insurance business? Maybe with this background it is surprising that only 17 recommendations were made.

During the commission's study phase and, even more so, subsequent to the announcement of the commission's recommendations, there has been an abundance of activity surrounding this issue. At the State level, Virginia became the first state to implement a law based on the Privacy Commission recommendations. Their law effective July 1, 1978, requires that individuals be notified directly and specifically about adverse underwriting decisions. Rhode Island, Maryland and the District of Columbia have enacted laws dealing with the confidentiality of medical information. Privacy Study Commissions have been authorized in Iowa and New Jersey.

An NAIC Task Force on Privacy presented an exposure draft of a model bill to the December 1978, NAIC Meeting. Since December, comments have been solicited, public hearings held and preparation of a final draft has been made for submission to the June NAIC Meeting. Basically, the NAIC calls for support of most recommendations at the state level. However, they would support an approach that allows for broad standards to be set on a federal level. Then, if state laws were not passed, the Federal standards would apply. HIAA and ACLI are approaching the issue in a similar manner.

On April 2nd of this year, President Carter sent Congress three bills on privacy including one on medical records privacy. A fourth bill is to be submitted in the near future entitled the "Fair Financial Information Practices" bill which is expected to provide national standards on the privacy of insurance records.

He said that the bill "is not intended to change the existing pattern of regulating insurance at the state level, and it allows state regulators to oversee compliance." Commenting further he said, "However, it will minimize the danger that a welter of differing state privacy standards will confuse the public and impose heavy costs on the insurance industry."

Least, we go on our way thinking this issue is only of concern to regulators and legislators, I would like to refer to some of the findings recently announced by Sentry Insurance from a national survey on privacy conducted by Louis Harris & Associates for Sentry:

1. 64% of the public feel a real concern about threats to their personal privacy. (Up from 47% a year earlier).
2. This differs from 70% of the bankers and 58% of the insurance executives who are unconcerned about threats to their privacy.
3. In general, 72% of the public feel most organizations ask for more sensitive information than is necessary and about half are worried about how it will be used.
4. The American public ranks insurance companies as the third biggest invader of privacy in the private sector after finance companies and credit bureaus.
5. On insurance companies specifically, 38% of Americans feel that insurers collect too much personal information and 61% of the state insurance commissioners agree with the public.
6. In an area of real concern to all of us actuaries and underwriters, some 65% of the public, 55% of the state insurance commissioners and 49% of Congress believe the types of personal information insurance companies can gather on individuals should be determined by law. Not surprisingly, 79% of the insurance executives disagree.

The survey goes further to outline some of the data which those surveyed feel as improper for insurers to collect. I will list some of the major items for life and health insurance applicants. As you hear these items, I ask that you try to imagine the financial impact on insurers if we were disallowed by law from obtaining this information. The percentages are those respondents who feel we should not have this data.

Applicant's lifestyle	77%
Applicant's moral character	71%
Applicant's income	70%
Other life and health coverages in force	63%
Applicant's criminal record, if any	60%
Information relating to claims the applicant has made to other insurance companies	55%

There was possibly a bit of sunshine in the report. Just over half, 53%



of the public feel that the insurance industry is justified in maintaining an insurance fraud suspect file. But is that response a partly sunny or partly cloudy forecast? After all, almost half disagree.

After digesting this information, some people feel that there is a twofold message for the insurance industry. First, we must delete information gathering where it is really not necessary. Secondly, and very importantly, we must explain to the public the benefits they derive when we collect and use personal information about them.

Against this background of growing interest and activity by the state and Federal legislators and regulators along with the interest of the public, it appears obvious that this issue is going to become a growing part of our lives whether we are actuaries, underwriters or executives.

Aetna has a lengthy record of concern about protecting the privacy of its customers and employees while meeting the company's need for personal information. As one of the first insurers interested in this issue, Aetna was instrumental in the 1974 decision of the American Insurance Association and American Council of Life Insurance to study it. Aetna's firm commitment to privacy probably began in 1975 with the appointment of the company's president, Mr. Bailey, to the Privacy Commission.

In May, 1975, a Privacy Council was formed from employees located in various areas of the corporation. These members were asked to help design and implement a corporate policy on the collection, retention, use and protection of personal information.

By March 1976, the Council had developed a broad Privacy Code that covered both employment issues as well as issues dealing with information about our customers.

The Council has continued to monitor the work of the Privacy Commission since separate privacy groups were established in each major division of the Company analyzing the effects of these issues on their own operations.

Six months after the formal Privacy Commission recommendations were presented to President Carter, the Aetna's Employment Privacy Policy was announced and implemented. As of January 1978, each employee may review and copy most of the records Aetna maintains on that individual. The initial list shows almost fifty different documents possibly held in various files throughout the company concerning one employee. There is the possibility that over half of these documents could have several different versions. An example of what is meant by different versions would be performance appraisals for each year of employment.

Employees were also notified of seven types of records that are unavailable for review because of legal implications.

Shortly after the Employment Privacy Policy was announced, the operating divisions (Individual, Group and Casualty) began implementing their own Privacy Programs which were completely in place by September 1978. Efforts were directed toward voluntarily implementing every

recommendation of the Privacy Commission that was practical. The only sections considered not practical by senior management were those where there could be adverse legal effects. Even in these few instances an attempt has been made to fulfill the spirit of the recommendation. The changes in procedures were spread over almost six months, primarily for the benefit of the producers and agencies who had to cope with yet another change in procedures.

Although there were many more procedural changes, I will mention only seven of the major activities effecting new business processing that we completed to comply with the recommendations of the Privacy Commission.

First, all applicants for individual life or health insurance now receive an underwriting notice that advises them of:

- (1) Basic information concerning the underwriting process.
- (2) What information we will collect to evaluate an individual's application, the sources of that information and the techniques we use to collect it.
- (3) The organizations to whom we may disclose information about the individual.
- (4) The individual's right to learn of the nature and substance of the information we maintain about him.

Giving this notice to our applicants has posed no problem for us, and we believe that consumer satisfaction will be increased if we are open about our processes right at the outset of our relationship with an individual.

In addition to this notice, each applicant is asked to sign a revised and expanded form authorizing us to collect information from his doctor and hospital, other insurance companies, consumer reporting agencies and the Medical Information Bureau. The authorization is only valid for two years. It allows the individual to request an interview by the credit reporting agency during normal business hours. A space is left for writing in a business hours telephone number. Our outside support organizations have agreed to supply requesting applicants a copy of their report prepared in our behalf. We believe all parties concerned will benefit from the improved accuracy resulting from these procedures.

Thirdly, we reviewed every interview form and every question used by the inspection companies. Any question we felt to be irrelevant to our selection process was noted. A letter was sent to each inspection company asking them not to ask those questions of our applicants and not to complete the information for us. Cooperative responses were received from these companies. In fact, one company stated it was revising all its forms for all customers to be directly correlated with our requests.

Another significant change we have made in our life and health underwriting practices is in the area of adverse decisions. We inform

an individual of the medical and non-medical reasons for rating or modifying his policy or declining his application. If medical information is the basis for the adverse decision, and if it was obtained either from the applicant himself or from one of Aetna's medical examiners, we will give the individual that information. If, however, the medical information was obtained from the individual's personal physician, we tell him only that the information forming the basis of the decision was obtained from the doctor. We also tell him that upon request, we will be happy to write to his physician explaining the detailed medical reasons for the adverse decision.

Our experience to date with this procedure has been favorable. We send out adverse underwriting decision letters on almost 20% of the individual health applicants and 7% of the individual life submissions monthly. Out of 350 letters from the health area, approximately 12 individuals a month—fewer than we expected—ask us to supply them or their physician with more detailed medical information. This new procedure has substantially diminished the number of complaints and inquiries we receive from applicants regarding adverse decisions. The procedure also aids our agents and brokers, who now are able to directly supply the customer the reasons for a decision in the form of a letter from us. We further protect our customers' rights by providing the reasons to them in a sealed envelope. The client can decide whether or not he wishes to tell his agent about the information we supply.

If a customer is not satisfied with the information we provide on adverse decisions, he is entitled under our Privacy Program to learn of the nature and substance of the information we have in our files. We decided that we would not make the full file available until we are provided limited statutory immunity under either a state or federal law, but we think that most individuals will feel that they can obtain sufficient information without gaining access to all the information we maintain.

We have reviewed, revised and refiled all our application forms to make sure the information we request is necessary, appropriate and not redundant. The new applications have been reworded so that an applicant will know what information is necessary for determining eligibility prior to issue and continuing administration after issue versus information used for marketing research. The latter portion is not required to be completed.

Finally, we have instituted a new procedure by which reports on physical examinations from our medical examiners are sent directly to the home office for review rather than being sent to our general agencies. This new procedure further protects our customer's expectations of confidentiality and our medical examiners wholeheartedly endorse this approach.

You may wonder what it costs to implement the Aetna Privacy Program. In the individual life and health areas (the Life Division), we estimate that during 1978, it cost almost \$270,000 for staff time during development and printing charges for new forms such as applications, pre-notices,

pamphlets and authorizations. Further, we estimate an ongoing underwriting and issue annual expense of roughly 60¢ per policy issue.

All of the above items are essentially related to new business processing. For all existing policyholders, we prepared a brief "stuffer" to be coordinated with billing cycles concerning the privacy issue, Aetna's privacy code, an offer for the client to learn the nature and substance of any personal information in our files and a description of how we handle that confidential information. We do reserve the right to disclose medical information only to an insured's personal physician.

Certain changes were also made in our individual claim processing departments. The underwriting authorization previously mentioned was developed to ensure that we could use that document for any contestable period investigations. We will not disclose to individuals what we know about them while a claim is pending or if a suit is threatened. However, once a claim is settled, we allow an individual to learn the nature and substance of our files. We will review any correcting or clarifying information.

Further, we will provide medical information only to the specific source upon receipt of an authorization from the insured. Again, we would not do so if litigation appears likely. Claim information is furnished to other areas within our organization only to persons having a need to know. An authorization is required to be in the possession of any other area that desires to obtain information from the claim files.

Having initially implemented the procedures I have mentioned, we are not ceasing concern with this issue. I am sure we can do even better in modernizing our traditional recordkeeping activities. I know that several of the procedures Aetna has adopted recently are already in place in other companies, such as the use of underwriting decision letters and having medical exams sent directly to your home offices. Opening up the insurance industry's processes to the public will go a long way toward dispelling much of the skepticism and suspicion currently felt by consumers about our practices. As an industry, we probably do many more things right than wrong. Instituting privacy programs will make this apparent to the public and we hope it will win for us the consumer support that is so vital to our continued success.

MR. ALAN FERGUSON: In continuing this discussion of the impact on underwriting of the Privacy Commission's recommendations and subsequent legislation, I have been asked to describe changes in the availability of underwriting information and in administrative costs. I have also been asked to comment on any resulting changes in morbidity.

In discussing these topics I will fall short of the Society's motto. I will be giving you my impressions and I will not be substituting demonstrations for these impressions. Since the subject is underwriting this may be appropriate. There is a lot of judgement in underwriting; it is not an exact science, and impressions are important.

The major area for concern is, of course, inspection reports. Insurers are not in any significant way restricted by privacy concerns from acquiring relevant and necessary information on applicants. Legitimate

needs for information are recognized in the Privacy Commission's recommendations. The prohibitions against certain forms of gathering information may have changed the ways in which consumer reporting agencies operate, but this is all to the good, and I do not believe that we will lack any significant items of information which we previously obtained.

Prudential recently made a study of inspections which showed a substantial decline in protective rates. Combined with increasing costs of reports this calls for a revision in our ordering rules. However, I am not convinced that the decline in protective rates is due to less effective gathering of information. The decline seems rather to be due to changes in our underwriting standards. For example, we no longer have substandard classifications for some personal characteristics such as occasional use of marijuana, sexual preferences or cohabitation.

Our study of inspections was of life insurance applications and we have not made any recent similar study of inspections of health insurance. I should mention that we have different standards for the ordering of inspection reports for health insurance than for life insurance. For medical care insurance, we order very few inspections. For individual disability income insurance we order inspections on all our applicants. At this time we have no plans for changes in our requirements for health insurance, although I suspect that the protective rate for health insurance has also declined--probably for the same reasons as for life insurance.

One effect of concerns over privacy is that inspection companies must have incurred substantial expenses in monitoring legislation, responding to the Federal Trade Commission, providing disclosure, and so on. These costs must be reflected in their prices, and while most of their price increases are due to inflation, the additional work because of privacy concerns must have had some effect. The result is increased costs to insurers--either directly because of higher prices or possibly because of increased morbidity as lives who were previously inspected are no longer inspected and as a result some persons are able to obtain coverage at standard rates who were previously charged an extra premium. Ultimately these additional costs must be reflected in premium rates.

As for the availability of information from other sources, there has been little change. There may be hospitals and doctors who employ more rigorous standards for authorizations than previously, but I do not believe we have experienced significant reduction in information. Attending physicians' statements have always been difficult to obtain, and the difficulty may have been only slightly increased.

The MIB survives--and is a good example of an organization which has adapted to the changing information environment in which we live. One concern expressed by the Privacy Commission was that the individual consumer lacked knowledge of the practices of our industry--he didn't know what information was recorded, who had it, why adverse decisions were reached or what his recourse was. The MIB used to be a rather mysterious organization--it wasn't even listed in the phone book. Well, it is now listed and notices are required which explain what it is and how it works. Anyone who wants to know what's in his record can find out.

There are, of course, some costs involved in this new MIB posture. Like the inspection companies, they have the costs of responding to proposed changes in legislation and regulation. They also have the costs of the company review program. As with inspections, these costs must be reflected in the charges which MIB makes to its member companies, which in turn must be reflected in premium rates. The fact that MIB charges have changed so little in recent years is attributable to computerization and a more effective organization. These have offset the additional expenses for lawyers incurred because of privacy. I'm not sure if lawyers or the public are the principle beneficiaries of concerns over privacy.

There have been some major administrative changes in underwriting as a result of concerns over privacy. At Prudential, we are revising our authorization forms to include a time limit as was recommended by the Privacy Commission. Other changes will be necessary to comply with the recommendation that companies must give notice of an adverse decision. The notice will have to give reasons for the decision and also explain how further information bearing on the decision may be obtained. These requirements do, in fact, already apply in Virginia.

Prudential used to give the agent an idea of the reasons for an adverse decision and leave it to him to explain to the client. We have already changed our practices and we now tell the client directly. We have been very pleased with the results; we think communications are better, and our agency force seems to agree. We have yet to extend our letters to explain how the client can get further information about a decision (as would be required by the proposed Fair Insurance Practices Act), but we are planning to do this soon.

Providing this information to the client is, of course, an added burden on the underwriter, and sensitivity must be used in phrasing a letter which is informative but not tendentious. How, for example, do you tell someone that he is not eligible for a disability policy because he doesn't earn enough after his agent has presumably told him that he does? Again, how do you explain that the work that a client performs doesn't qualify him for the lower price occupational class that his agent has told him that he does qualify for?

Complying with these requirements has its cost, which will be reflected in premiums. Cumulatively, these legal and administrative expenses must come to a sizeable number of dollars. They are the price we pay for living in a regulated society. It would be interesting to compare the costs with benefits, but there are so many hidden costs involved that it would be very difficult to determine even an approximate figure. We can say how much it costs an underwriter to prepare a letter, but how much time is spent in reviewing proposed legislation trying to get changes made and so on? How much executive time is diverted from what might be more productive work? In any event, such a comparison of costs and benefits would be an actuarial way of looking at the situation--and I don't think that even if the costs were known that legislators or regulators would be dissuaded from responding to their perception of the public's concerns over privacy.

That these concerns are very real was shown in the recent public opinion survey sponsored by Sentry Insurance. Forty percent of those surveyed

thought that insurance companies asked for too much information. Many felt that we had no business asking about income or whether there is other health insurance in force. A majority felt that it was improper that there should be a computer bank with records of rejections or ratings. My reaction to this particular response was that the question which prompted it revealed a misconception -- perhaps deliberate -- of the role of the MIB, which, as you know, does not have records of underwriting action (rejections or ratings) and therefore cannot share such information with member companies. The survey and the misconception do confirm, however, that we have an important and continuing job to do in persuading the public of our need for information and that we use the information with sensitivity and discretion once we have it.

The need to justify our need for information must be considered as the proposed Disability Insurance Records System is evaluated. This system, which has been developed by our HIAA Disability Insurance Committee, would provide data on applications and possibly claims for disability insurance. The data would include identifying information on the applicant and information on the plan and amount of benefits applied for. The intent is to help protect against over-insurance. Companies would be alerted when an applicant intentionally or unintentionally was putting himself in a position to profit from a disability and could take appropriate action. A survey of disability insurance companies has just been completed to determine their interest in participating in the proposed System. The reaction has been generally positive, and the next step is to check the legal problems and make sure that the system is feasible.

In summary, as I have stated, there has been little change in the availability of information for underwriting purposes. There certainly are increased costs, probably sizeable, but the amount is undetermined. I have said very little about increased morbidity--because there is no evidence that I am aware of that would attribute any increase in morbidity costs to restraints on underwriting.

There is, however, one aspect of the Privacy Commission's recommendations which could have a significant effect on morbidity costs. This is recommendation #1, which calls for government reviews of the availability and use of information. It suggests that government may respond to public concerns and prohibit the use of certain information. If the result was that insurers were prohibited from charging rates based on sex or occupation or even health status, then clearly there would be a significant change in morbidity costs.

MR. LAWRENCE M. AGIN: I wonder if we are not barking up the wrong tree in trying to get statistical data to support every refinement in our underwriting manuals? Nobody quite knows what the state regulators require or what degree of proof is involved.

With regard to the various discrimination laws, they all include a word that is quite key. The word is "solely." My company feels that we do not discriminate or rate anybody solely on the basis of any one thing. We look at all aspects of a case. In particular, we look at the reason for a disability and not just the fact that a person is disabled. If he has a progressive disease involving blindness, then we rate for the progressive disease, not for the mere fact of blindness.

We are trying to provide statistical evidence in a different frame work. We take whatever studies are available (i.e., medical, actuarial, and so forth) and try to isolate the extra risk associated with individual impairments; but very few people have just a single impairment. Thus, we have to rely on the underwriter's judgment to put these persons into a group. Once we have a group, we can let actuarial principles take over. If our underwriters say that these people belong in a 50% extra rate table group, we can then study that group. If we get 50% extra on that group, that becomes the statistical evidence to support our actions. We just could never get statistics that apply to each unique individual.

In its purest form, this is supposed to be a scientific question and the Society is the scientific body for the actuarial profession, so, I wonder if the Society could not get involved in answering these legislative challenges? It does not make sense to me, for each individual company to tromp before the regulatory authorities with their own story, as there really is not a significant variance in ratings between companies and their actions are generally based on the same sources of data.

MR. HOLMES: I well understand the frustrations, Mr. Agin, that you are voicing. Unfortunately, the hard fact is that insurance departments now feel they have a right to regulate underwriting practices and that right is going to get more specific. I agree that you certainly cannot get statistics on everything and you cannot scientifically justify every action you take. But I think, in general, it is important to be able to rationalize, as precisely as you can, what you are doing.

We are trying as an industry to respond to specific pieces of legislation and regulation that are now appearing on the basis of our model risk classification bills. Unfortunately, one of the faults of our industry is that it tends to be a little hindsighted in its regulatory activities. Therefore, some states have gone ahead and done things before we have had an adequate model to proffer to them as a solution. Still, we are trying to be uniform in our regulatory response, to show that indeed there are some scientific principles at work here.

MR. ROBERT J. SHLIFER: I was just wondering if anybody wanted to comment on the Federal Kemper decision in Iowa and how that might affect risk classification?

MR. HOLMES: I will comment very briefly on that. Frankly, I do not think it is of great relevance. There is a blindness regulation in Iowa. The Kemper companies were taken to court and got a satisfactory ruling on the regulation. The holding was that the statute does not authorize the Commissioner to prohibit certain classifications, but it does authorize him to review classes set by an insurance company and to see that the company does not discriminate unfairly between individuals of the class. Such authority applies to rates as well as dividends or other benefits. The problem with this case was that it was decided in the lowest county trial court and the case is already on appeal.

This decision illustrates a good point. The courts are coming in where there are gaps and they are making decisions about our business. It would behoove us to make these decisions first, then the courts will not be able to arbitrarily make business decisions for us. That is really what is behind so much of our efforts.



MR. WILLIAM R. BURNS: We seem to be saying slightly different things in regard to sex classification. My purpose is not to try to draw attention to any difference of opinion, but rather to state my view that sex classification is a very important classification to retain in the insurance selection process. If the industry were forced to abandon sex distinctions, the main losers would be the public and particularly those consumers who need individual accident and sickness insurance. I was wondering if Mr. Ferguson might like to clarify what he mentioned previously?

MR. FERGUSON: Well, my feeling is that sex distinctions do exist and should be properly reflected in life, health and annuity rates. My point was that if it were mandated that we could not have these distinctions, then we could still survive. Naturally, I hope that this does not happen.

