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**RISK CLASSIFICATION POLICY ISSUES—
LIFE INSURANCE**

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1. Factors for life insurance risk classification - sex, age, physical, occupation, habits
2. Current changes in life insurance risk classification
 - a. Changes - smoker/nonsmoker, preferred risk, paramedical
 - b. Impetus for change - social, political, economic
3. Future changes in life insurance risk classification
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4. How to influence those future changes
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MR. CHARLES A. ORMSBY: This is the Concurrent Session for first, a panel presentation and, secondly, a discussion by both the audience and the panel of risk classification policy issues pertaining to individual life insurance.

A well-known and highly respected life insurance executive (Robert Van Fossan, Chairman and Chief Executive Officer of Mutual Benefit Life) has stated that, in his opinion, the current challenge to our risk classification system is, with the exception of inflation, the most serious problem facing the life insurance industry today. It is my impression that there is general agreement throughout our industry with this conviction, which means, among other things, that the Program Committee has given us a topic of vital interest not only to actuaries and underwriters but also to all other executives interested in the future of individual life insurance as we know it.

Those of us who have had actuarial and/or home office underwriting responsibilities since the early 50's know that the environment in which we have performed our functions has gradually been altered in significant ways over that period. It was not long ago that home office underwriters were free, for the most part, to obtain whatever information they considered pertinent and reasonable in cost. Under today's conditions, home office underwriters and actuaries have to contend with the clearly and loudly expressed public concerns over invasions of privacy, with the charges that underwriters are violating confidentiality of medical and other information, with the public statements that underwriters are getting more information than is needed, and so on. Years ago, we were not only left to our own resources with regard to obtaining underwriting information; we were also permitted to use our own judgement as to what influence such information would have on our underwriting decisions, which are made, not in a laboratory or an ivory tower, but in a highly competitive business environment. Today, we are still applying essentially the same principles of risk selection but with many constraints that did not exist only a few years ago and may in some instances lead to subsidies of one class of risk by others.

One of the first constraints to invade our world of home office life underwriting was the elimination of race, even though at the time there were, in the opinion of some, supporting data for considering this a factor in combination with others. Our democratic society decided that there were overriding reasons for eliminating this distinction in risk evaluation.

It is not necessary at this point to mention the many other underwriting constraints under which we now operate which did not exist prior to 1950. I think that, to some extent, we must admit there have been weaknesses in our system which have made us vulnerable to attack by consumerists, legislators, bureaucrats, and even some of our applicants, particularly those not eligible for the lowest cost classification. Among the alleged weaknesses or deficiencies in our risk classification system are or were:

1. The noticeable differences that existed until about 1970 in the coverages offered to male and female applicants.
2. The allegation that personal prejudices were, in some instances, affecting our underwriting decisions. For example, some people have felt we did not adjust soon enough to the changing lifestyles that appeared in the 60's.
3. The lack, in certain areas, of pertinent data sufficiently conclusive to support our underwriting decisions, such as in the area of multiple medical impairments, psychiatric treatment, etc.
4. Conducting our operation in such a fashion as to create the impression among members of the public that we were running a secret society. The low profile of the MIB until about ten years ago may be considered an example of this.
5. Our tapping sources of information without notifying the applicant or without getting his express or explicit permission. The Federal Fair Credit Reporting Act of 1971 has changed this part of our modus operandi.

While our system of risk classification has weaknesses, alleged or real, there are also strong defenses. It seems to me that the principal justification for the system is that it is based on a pricing structure for the various subdivisions which accurately reflects the expected losses, makes possible the equitable treatment of policyholders, and is viable and sound from an economic point of view because it keeps anti-selection within practical bounds. The unhappy fate of the assessment societies is common knowledge. Our capability to apply the present system to current conditions is being enhanced by the great multiplicity of investigations of the many and diverse factors affecting mortality. Our motivation for accurately applying the system that is constantly being improved is provided in part by the increasing competitiveness of the marketplace.

As we consider our underwriting problems from the standpoint of our many publics outside the life insurance industry, we should note that the invasion of our territory, so to speak, that the limitations we must now observe in applying the principles of risk classification have evolved in small installments over a period of many years. We have adjusted to these mandates, somewhat reluctantly. The important question now is how can we stem the slow-moving tide and maintain our system of risk classification under the conditions of ferment which exist today and under those conditions that we foresee as impinging further on our freedom to continue the restricted classification system under which we are now operating.

MR. JOHN H. COOK: In the early days of life insurance underwriting, there existed an environment totally different from what exists today. When I say the early days, I am not limiting myself to the 18th or 19th century. I go two-thirds of the way through the 20th century and up to a time only about ten years ago. In those early days, the concern of the underwriter was with security.

It was the job of the underwriter to classify the risk based on his best judgement and to use classification parameters that were simultaneously the most convenient and the most effective to accomplish the objective. If an applicant was a member of a group which, as a group, gave rise to higher than standard mortality, the applicant was denied the standard classification. The underwriter was not concerned with the difference between "cause and effect" and "spurious correlation." If the correlation was there the underwriter would be conservative. He had no one to answer to but his boss. Things have changed. We have legislative and regulatory classification restrictions. We have privacy controls. We have disclosure requirements. We have demands from pressure groups. The underwriter today has to answer to many individuals. If he approves the \$100,000 application today, in spite of his gut reaction against it, he may have to defend a first year claim tomorrow. If he doesn't approve the case, he may have to explain the reasons tomorrow not only to the agency vice-president and to the sales representative involved, but also to the examiner from the insurance department. We walk a tightrope.

What is the environment we live in today? We live in a time of challenge. We are challenged that our risk classification is excessive. We are challenged if we price our product based on the sex of the applicant. We are challenged if we make underwriting distinctions based on lifestyle. We are challenged if we classify the physically handicapped as a substandard risk.

Let's have a review of the bidding and see where it is that we stand. There are a number of underwriting parameters that are significant. What is more interesting to consider first other than sex? Mortality differentials by sex have been with us for a long time. Pricing differentials by sex in the life insurance products are more recent. This latter fact is often cited by the opponents of sex segregated pricing as an argument in support of their claim. The life insurance industry used to get by with unisex pricing. Since they did it before they can do it again.

This argument fails to take account of why unisex pricing was common 20 years ago. Early this century Ordinary as opposed to Industrial life insurance on females was quite uncommon. Sex segregated pricing would have been pointless. As female coverage began to increase it was still relatively limited. The average size of female policies was smaller than for males and very few female policies were issued for amounts much in excess of the average. Prior to the time of price variation by size of policy, the higher average expenses per \$1,000 of female coverage had to be offset and the more favorable mortality was available for this purpose. As the years went on, it was not uncommon to exercise underwriting liberalizations in favor of females to recognize the more favorable mortality. These expediencies were quite reasonable in their day.

The time came, however, when expediencies had to give way to realities. The mortality differential between the sexes in the general population increased between 1920 and 1970 from 108% to 175%. What was the change in insured life mortality in the same time frame? Nobody knows how it changed because nobody knows what it was in the 1920's. Insured life mortality experience by sex is more readily available today than it was at that time. The first intercompany data that was sex segregated covered the period from 1955 to 1957. The increase in the volume of female coverage increased the urgency for direct recognition of mortality differentials. Pricing by size has eroded the extra source of margin in the larger policies and the more favorable female mortality experience, especially the dramatic increase in the number of large amount female policies, demanded an explicit recognition in the pricing structure. It was no longer satisfactory that underwriting liberalizations would produce average female mortality comparable to male mortality. What about the females who were "better than average" in mortality? This same recognition has become manifest in male pricing. It is common today to price a special product for male applicants with better than average mortality.

It makes no more sense to revert to unisex pricing than it does to do away with the select risk pricing for males. Another consequence of the increased proportion of female experience in the total insured population has been its effect on the experience tables that fail to reflect the sex differential. A current unisex table would generate minimum standards for reserve liability that could be inadequate for a mix of business that consists mostly of male risks. Furthermore, technological breakthroughs have produced electronic data processing capabilities which make the use of sex distinct tables more feasible than it was 20 years ago.

Today the insurance industry stands at the crossroads in terms of pricing by sex. I know which way I want to go. No one knows yet which way I may be forced to go.

I will not bore you with elaborate discussion of the various issues in the insurance world today concerning pricing variations by sex. We all know of the landmark decision in the Manhart case. We don't know yet all of the consequences of that decision. The EEOC, TIAA-CREF, and the New York Insurance Department have differing interpretations. We have the Dingell Bill, or H.R. 100, in the Federal House of Representatives and its companion bill in the Senate. The state of Oregon has House Bill 2700 that would outlaw any price distinction in an insurance product based on sex. Meanwhile, we have California Assembly Bill 335, approved on June 2, 1978 and already effective since January 1, 1981, mandating life insurance pricing that takes account of the mortality variations by sex.

I have discussed one single parameter and its importance in the pricing of our product. There are many other important parameters; their numbers are legion. I said that we are challenged because of the reflection of these parameters in the pricing of our product. To quote a politician of 50 years ago, let's take a look at the record. More than half of the applications that are denied insurance at standard rates involve unfavorable build, unfavorable blood pressure or both. Our industry has just completed the most extensive mortality investigation in history involving one or both of these impairments. No other study in the medical world or in the insurance industry can compare with the volume of build and blood pressure data involved in this investigation. The 1979 Build Study was published last year. The 1979 Blood Pressure Study has been printed and will be distributed some time next month. These two volumes document the skill of the underwriter in the art and science (because it is both an art and a science) of classifying physical risks in terms of these two impairments.

These two are not the only impairments giving rise to variations in the level of mortality. In fact our industry has also recently completed another investigation limited to insurance issued at substandard rates. That study was not restricted by type of impairment. It included all classes of risk subject to extra premiums. It was based on just under 50 billion dollars of exposure of such substandard life insurance coverage. What did that study show? It showed a remarkable correlation between the mortality classification based on the judgement of the underwriter and the mortality experience that emerged from substandard rated business.

This brings me to my concluding remark. I quote to you now what I heard not too many years ago from a gentleman for whom I have the greatest respect. There was a discussion at a Tarrytown meeting of the New York Actuaries Club in 1977 concerning the restrictions being placed on the risk classification process. I heard Andy Webster speak from the floor at that session and his comment was this: "one of the things you can never take away from an underwriter is his right to use judgement."

MR. MICHAEL J. COWELL: I'm going to cover the second topic first: the impetus for current changes in life insurance risk classification. I will have a few comments on the changes themselves, and some of the results of those changes, but first I'd like to share with the audience some thoughts on the question of "why". Why are our principles of risk classification, that for so many years seemed practically immutable, all of a sudden, like almost everything else in our business, coming under such pressure for change? I'll try to answer that in two words - future shock! Events that in a previous era would have taken place over decades are now compressed into a year or two, or even a matter of months.

I'll begin with the economic forces of change, because that's the aspect with which most of us involved in risk management are closely involved in our daily work. However, you cannot go too far before you become involved in politics and social issues. These three aspects of our subject - social, political and economic - weave an intricate web around it.

We all know the underlying economic rationale for insurance. It is to manage the basic uncertainty of events that for any one of us have a small likelihood of occurrence, but that represent a major financial impact for the ones they do befall. From this basic principle of risk spreading we can derive a utility theory of insurance to show that in a free market economy where risk is a factor, but where most participants are risk averters, the economy is better off with an efficient risk spreading mechanism than without one.

In such a free market economy, insurance pricing will work naturally to develop risk bearing charges that reflect the different degrees of risk being insured. But if the risk pricing mechanism ignores significant differences between classes of risk, then competition will attract away risks that are being overcharged and create new and increasingly refined categories of risk until the competitive advantage of further subclassification is balanced off by the economic cost of operating the system.

This doesn't mean that we have to assign each risk to its own individual class of one; rather, it is a matter of grouping risks that are expected a priori to have roughly the same chance of incurring loss, and establishing a common price for the class based on this average expected loss.

That, in a nutshell, is the economic argument for risk classification. There is nothing profound, nor anything that isn't already covered in the Academy's Statement of Principles on Risk Classification; but there is enough to get us into a pack of trouble politically. The political issue arises in determining what are "similar risk characteristics" for each class and, more importantly, how and by whom they are determined in fairness to the individual risks that are so classified.

Those of us in the insurance business have traditionally thought that since it is our companies' underwriting capacity that is being exposed to risk, that we should also have the prerogative of deciding who falls into which class. Indeed the 1976 Report by the Stanford Research Institute on the Role of Risk Classification in insurance supports this position. The report concluded that restrictions on classification hamper the efficient operation of private insurance arrangements in a free market economy. Limit or destroy the freedom to classify and you won't have a free market system for very long.

Of course, this basic economic logic does not deter some politicians, and when you listen to what Senator Metzenbaum says in support of his Nondiscrimination in Insurance Act (S2477) you may find it difficult to realize we're talking about the same system: "It is essential in a society premised on the principle of individual liberty," the Senator tells us, "that persons be treated on the basis of their individual conduct and characteristics."

This is not bad, as far as it goes. "Issues of such magnitude," he goes on to say, "should be decided by the public's elected representatives, and not left to technical experts employed by insurance companies. The time has come to protect the fundamental civil rights of insurance policyholders. The Nondiscrimination in Insurance Act will accomplish this goal."

Now I don't underestimate for one moment the Senator's ability to persuade Congress that it should protect the fundamental civil rights of insurance policyholders. I submit, however, that not only will his bill not achieve that result, but that it will do irreparable harm to the private insurance system. This is a matter of more seriousness to us than we may recognize.

It is convenient to think that the public views a free market economy as compatible with the principles of individual liberty in a democratic society. I recognize that this statement alone could provoke a lot of discussion, but for this audience, I'll take that as given. This suggests that we should do all we can to make sure the private system has the freedom to operate so as to best serve the public. Only if it demonstrates that it cannot do the job should we expect government to take the system over. What we should not do is virtually guarantee that the system won't work by crippling free choice and expecting the private system to assist the government in its income redistribution efforts. We have seen far too many examples of the executive or judicial branches reaching such decisions almost solely on the basis of political pressure from special interests attempting to shift the burden of redressing social problems entirely onto the private sector.

And yet we find that the Manhart and the Colby College cases are already being used to challenge the basic concept of pooling similar risks. The Manhart case was one of those marginal 4 to 3 situations in which different groupings of Supreme Court Justices lined up on either side of the several opinions delivered. Chief Justice Burger, although he joined in part of the majority opinion, also filed an opinion dissenting. He argued that when it becomes impossible to tailor an insurance or pension arrangement to the individual, nothing should prevent the application of reliable statistics to individuals for whom the facts cannot be disproved until long after the planning, funding and operation of the arrangement has been completed. In a separate dissenting opinion, Justice Blackmun also considered it unrealistic to force an individualized analysis upon what is basically an insurance context.

For the past two centuries, the private insurance system has shown remarkable ability to adapt to the changing needs of society, developing systems to identify successively finer subgroupings of the population as risk classes. Our experience at State Mutual of distinguishing between smokers and non-smokers as separate risk classes is but one example of how the forces of competition if left alone, will work to the advantage of the consumer public.

Now I would be the first to admit that even this nice sounding theory, if carried to its logical extreme, could also cause us problems. As the number of risk classes increases and each class becomes more homogenous, it obviously loses something in credibility. In a similar discussion at the Hartford meeting last year, Bart Munson, Chairman of the Academy's Risk Classification Committee, questioned whether with further refinements in our risk classification system we would not soon reach a point where we charge 6,000 different levels of premium for a portfolio of 10,000 lives.

I think this is an unlikely extreme; the cost alone of such a classification system would render it uneconomical and, in the sense of what we are really trying to accomplish, this would appear to be an unnecessary complication. Maybe what we need is a classification system in which each risk is translated into a single linear measure that I will designate as "biological age."

It is popularly misconstrued that actuaries rely heavily on the measurement of life expectancy in developing financial estimates for insurance and pension plans. Perhaps we should give up trying to explain that we really don't use the value of e_x in quite that fashion, and see if we cannot in fact devise a system to take the underwriting characteristics we currently use and assign risks into classifications that, while kept separate for study purposes, are combined for pricing. Then we might not need many more premium rates than the number of discrete intervals currently recognized in the mortality table and a system of classification could be designed to assign risk based on individual characteristics. This approach might enable us to simplify considerably the pricing of short term coverages and other insurance plans where mortality is assessed in the form of a periodic charge and where benefits are not designed to be contingent on chronological age. Such a system might assign into the same premium grouping with equal life expectancy at issue a 43-year-old male smoker of normal build and no other impairments, an overweight 47-year-old female smoker and a 50-year-old male nonsmoker in excellent health. Perhaps the development of such a system would motivate us to refine our analysis of risk factors and, through a combination of medical and statistical knowledge, to classify risk according to the most significant discriminants of mortality with all factors translated into this single value of biological age.

I recognize that this is an overly simplistic description; it would require much more definition, and it might work out to be more costly than our current classification methods. However, it would have several distinct advantages:

It would employ methods of quantitative analysis that are currently available, but that have not been extensively used in mortality risk measurement.

It would be individually based.

It would preserve our prerogative to classify risks for mortality study purposes and to study our experience under those classifications.

A serious and often overlooked consequence of prohibiting the use for pricing purposes of distinctions such as sex that we know produce differentials in mortality would be the risk of losing these distinctions in the analysis of other variables that are still permitted. Regardless of whether sex was ultimately allowed as a criterion in pricing, we would still need to retain the distinction in order to study other criteria. A smoker/nonsmoker study, for example, would be of minimal value if it were not conducted on a sex distinct basis. One further advantage in the use of biological age as a measure of mortality risk is that it might even make our insured public more conscious of their health. My experience is that most people care less about mortality statistics; more likely to get their attention are the factors affecting their own life expectancy. If a not so healthy 40-year-old knows that he is being charged as much for his insurance as a healthy 50-year-old, the realization that these are years off his own life might encourage him to do more to improve his health than if he's simply told that he is being charged a special class premium because he was underwritten at Table F.

Among the various social evolutions of the past generation is the greater responsibility that more people seem to be accepting for their own health. Twenty million joggers, and other assorted exercise and health "buffs" did not appear from out of nowhere. The social phenomenon of holistic health, to which our profession was exposed at the Society's 1979 meeting in Banff, is probably one of the positive aspects of the so-called "me" generation; the conviction in this example is that no one has more responsibility for my health than I do and how I eat, drink and live can have a significant effect not only on the length of my life but on its quality also.

From this perspective, it is only a short step to the view that if I take better care of my health than I should be permitted an advantage economically, in terms of lower life and health insurance premiums; and yes, it may also mean being penalized in terms of higher pension costs.

In my discussions outside the actuarial profession, I find strong acceptance of individual responsibility for one's health. I believe it can be an effective argument with the unisex lobby against putting everyone in the same class, but I admit that we have a lot of work to do before we can begin to translate such concepts into practical risk classification and underwriting systems.

I admit too, that in attempting to capitalize on this social phenomenon, we might be expanding the role of life underwriters beyond their traditional function of impassively measuring risk, and could be involving them in actions that might lead prospective insureds to change their health habits. I envision a sort of bio feedback system in which the measurement of mortality risk makes those being measured more aware of what they can do to improve the risk and, in so doing, actually reduce it. It could conceivably open up a whole new area of actuarial and medical underwriting specialties in individual mortality risk management.

The one serious impediment to this approach, aside from the question of cost, is the issue of privacy. Individual health profiles require more information about a prospect than we currently obtain. In their 1979 study, "Dimensions of Privacy", the Harris Poll found that 60% of the public were concerned about the threat to their personal privacy, with a large majority feeling that insurance companies should not ask for information about life style, moral character or income. A sizeable minority even felt that insurers should not even ask applicants questions about their age, sex, employment, smoking status or drinking habits. So while Senator Metzenbaum wants us to classify people on the basis of their individual conduct and characteristics, people themselves are not at all sure they want to divulge the details necessary to carry this approach out.

Clearly, our industry has a major education job on its hands. We have to keep reminding certain members of Congress of the fundamentals of free market insurance mechanisms, and we have to make the public aware that if they expect individualized treatment they will have to be willing to let us have the information necessary to make individualized attention possible.

Let me now discuss changes in nonsmoker and preferred risk classifications and in paramedical underwriting to see how many of these concepts have already been or can be put to practical use.

At the risk of a little self congratulation, I believe that our industry has had more foresight in some of these matters than we may have taken credit for. Specifically, over the past several years, more insurers have come to recognize smoking habits in individual life insurance underwriting. Two years ago, when these life companies still numbered around thirty, one survey showed that in addition to the nonsmoking criterion, about a third of them included build or blood pressure requirements and in some cases both. A few offer super select discounts beyond their nonsmoker rates for prospects in unusually good health.

My own analysis of a dozen or so of State Mutual's close competitors in individual life insurance shows that all but one offer insurance at lower cost to nonsmokers, and that more than half combine nonsmoking with other personal health factors to come up with what is tantamount to a preferred risk classification. As just one further indicator of the profusion of new risk classification criteria spawned by the smoking issue, one of the leading national insurance publication services will be distinguishing in its 1981 comparison of interest-adjusted indices between those companies that offer a straight non-cigarette smoker discount to standard risks, those who add a build requirement, and those that add other factors such as medical and family health history.

The significance of these new sub-classifications of risk from a mortality standpoint will probably not be known for several years as the experience of these companies develops. I have not allowed enough time in my presentation to speculate as to what this experience will show, but suffice it to say that the Liaison Committee of the Society and ALIMDA does have a task force investigating the feasibility of conducting an intercompany nonsmoker experience study.

I commenced on an economic note, and that is also the basis of my concluding remarks. Until the early 1970's, a majority of the business underlying the Society's mortality statistics on standard ordinary insurance was issued on a medically examined basis. While medically examined business continues to represent the largest single component of the aggregate exposure in the most recent Society Reports, covering the period between 1977 and 1978 anniversaries, it has for the last two reports been outweighed by nonmedically and paramedically issued business combined. In the 1979 Reports, medical issues represented 46% of the aggregate exposure, nonmedical 41% and paramedical issues the remaining 13%. In terms of new business, however, medically examined issues have not represented a majority of the exposure for the last five such Reports. Paramedical issues have grown from almost nothing over the past seven or eight years to the point that they represent almost 30% of new business exposure in the 1979 Reports, with medical issues representing 35% and nonmedical the remaining 36%. If this trend continues, paramedically issued business will outpace both medical and nonmedical in just a few years.

The motivation for the trend is clearly economic. Faced with costs averaging \$25 or more for routine medical examinations at the same time that margins for expenses in current premium rates are being forced competitively downward, underwriters are trading off a small additional element of mortality for the lower and more stable cost of paramedical examinations or the elimination of this cost entirely through nonmedical issue.

We don't have time to review the experience according to these three under-writing methods; suffice it to say that the Society's recent Reports show that experience under paramedical issues is much closer to that of medical experience than it is to nonmedical. In two of the past five Reports in which paramedical experience has been shown, it was actually more favorable than that for medical issues. I have no explanation for this phenomenon, but there is some speculation that paramedics who specialize in routine examinations for insurance applications may actually do a more conscientious job than otherwise busy physicians.

In summary then, our traditional risk classification systems are under pressure from a variety of social, political and economic forces. We have two clear choices. Either hold fast to yesterday's way of doing things, and run the risk of letting these forces overwhelm us, or ride with them to shape new methods that incorporate the knowledge and sophistication that our profession is trained to bring to bear on this issue. The political events of recent months suggest changes in the public attitude that had previously been attributing to government more authority and capacity to right all the wrongs perceived in our social and economic systems. I urge all of you who have an influence on the risk classification system of our private insurance industry, to take advantage of this shift in the political climate; seize on the opportunities to shape this system, make it more responsive to your customers' needs, and apply your technical skills to so strengthen it that when the next onslaught comes, as inevitably it will, our prerogative to classify risk will survive and with it the continued freedom of private insurance.

MS. LINDA B. EMORY: Life insurance risk classification in its present form may not have a future!

In a democracy, no risk classification process can exist if a majority of the public does not believe that the practice is fair. According to Bob Froehle of the AGLI, 40% of the American public today does not believe that risk classification is fair. We have two options with regard to this serious questioning of risk classification:

(1) we can either educate the public that risk classification is in their best interest

or (2) we can come up with techniques that do away with the perceived unfair elements of risk classification.

The 1980 Modifying the Attitudes of the Public Survey (MAP) asked whether ten specific risk classification factors should be considered in determining life insurance premium rates. Here is the result of that survey:

<u>Risk Factor</u>	<u>Percentage of Respondents Answering</u>		
	<u>Should Be Considered</u>	<u>Should Not Be Considered</u>	<u>Uncertain</u>
Age	71%	23%	6%
Hazardous Occupations	70	23	7
Cancer	69	22	10
Heart Disease	69	21	10
Hazardous Hobbies	67	24	9
Smoking	63	28	8
Weight	55	34	10
Physical Handicap	42	42	16
Marital Status	26	67	7
Sex	22	72	5

In general, this survey is more encouraging than the statistics I quoted earlier. Perhaps this is because it relates only to life insurance. Actually the whole 1980 MAP survey indicates a softening in the public's attitude toward the psychology of entitlement. The public seems to believe that age, dread disease and the factors within the control of the insured such as hobbies, smoking and weight should be considered in determining rates. They are split on whether physical handicap should be considered, but apparently are more favorable to considering this than in the ACLI previous surveys. According to this survey, the public feels very strongly that sex and marital status should not be a factor in life insurance risk classification.

Given the public attitude about our risk classification process, we shouldn't be surprised at what is happening on the regulatory front.

Sex As A Risk Classification Factor

The risk factor which is most seriously under attack is sex. Marital status is not often used and is of minor consequence to the industry. At the federal level, there is both a House and Senate version of a bill which would make it unlawful to discriminate in the sale, issuance, underwriting or rating of any insurance policy on the basis of sex. This bill has powerful support, and we can expect that it will be pursued despite the Republican tide in the November elections.

In contrast, the state regulators and our profession are gearing up to make sex an even more important risk classification consideration for life insurance. The NAIC has proposed amendments to the Standard Nonforfeiture and Valuation Laws, which contain the 1980 CSO Mortality Tables with separate rates for females. I understand that the New York Insurance Department has recently refused to approve a pension unisex table required by the EEOC.

Examples of the reasoning of the proponents of the federal bills can be found in a recent article in The University of Chicago Law Review entitled "Sex Discrimination in Insurance." This article documents some of the factors which could account for the mortality differences between the sexes. They cite **behavioral** factors which have plagued males disproportionately: smoking, alcohol consumption, reckless driving and the "coronary-prone" Type A personality trait.

They go on to make a case for using personality trait for risk classification since they state that males and females with the same personality trait have similar mortality. They cite the possibility that job-related stress contributes to the higher mortality of males. They state that women have recently benefited from a decline in maternal mortality and the techniques for detecting cancer of the breast and reproductive organs. They believe many of the factors that have benefited female mortality in the past will not occur in the future. Rather, they cite reasons that male mortality will improve rapidly. They challenge our tables on insured annuitants of the past as being inappropriate for this changing distribution of working women of the future. Furthermore, they believe that sexual discrimination, like racial discrimination, should be forbidden in risk classification as being against the public interest. They believe the use of separate mortality tables in the case of employee benefits is forbidden by law.

Despite the more favorable state posture, the overwhelming current public opinion and strong arguments against sexual discrimination lead me to believe that we may very well have to abandon separate rates by sex in the future. We could substitute personality trait if studies can actually substantiate such a factor and if this could be easily determined and accepted by the public. We already use smoking, alcohol consumption and reckless driving to some extent. I personally believe the strongest element of the difference in mortality comes from female biological superiority. However, we must be sensitive to the other factors that must also favor females that are influenced by changing social roles and behavioral factors and which may be credible and acceptable by the public for risk classification purposes.

Limitation on Use of Physical Handicap for Risk Classification

The other risk classification factor which is actively under attack by regulation is physical handicap. This has popped up in various states in the form of statutes which prohibit rating or declination for a specific handicap. The law may prohibit rating or declination for a physical impairment unless the insurance company can statistically substantiate its action. The problem with these bills is that they could be and sometimes are interpreted to include dread diseases such as cancer and heart disease, which probably weren't meant to be covered. Also, past statistics just are not available to substantiate anticipated mortality experience for some of the impairments we rate and the clinical factors we take into consideration. The NAIC Model Regulation on Physical and Mental Impairment has helped us cope with this situation.

I used to think that if the life insurance industry were not allowed to rate or decline for a physical or mental impairment, then we would basically be out of business. The insured would only need accidental death coverage until he knew death was imminent. We could not offer life insurance where only the unhealthy would apply. I am still convinced it would be a very difficult situation for the industry.

However, what do we see going on today? We are doing less underwriting than ever before with fewer ratings and declines for physical impairment. In 1977, Life of Georgia rated 5.2% of its applicants; in 1980, this percentage dropped to 2.3%. We're using more mass merchandising with little or no individual risk classification. A product type that might be used if use of physical impairment were not allowed is the guaranteed issue plan with graded life benefits. This is the plan that has become so popular for small amounts at the older ages. Full benefits are typically granted for accidental death from issue with near return of premium for death from natural causes in the first few years. As long as age could be used to set insurance amounts and premiums, this approach might just be a possibility.

Future Risk Classification

I do believe that the future will allow us to continue the more crucial elements of risk classification that we have used in the past such as age, hazardous occupations and avocations, and history or presence of disease. The public seems to support this action.

I believe we will see even greater use of the factors of lifestyle that support longevity such as nonsmoking, exercise programs, and perhaps nutrition. This is because the public believes credit should be given for factors that are within a person's control. Also the public is becoming more realistic about the cost of what is being provided, and they are less willing to foot the bill for people who deliberately are not taking care of themselves.

There will be less use of the classic underwriting tools and broader sub-standard rate classes in the future. More guaranteed issue or simplified underwriting techniques will also be used. With the cost of underwriting increasing at the same time mortality is improving and we're rating and declining less, we cannot cost justify getting a lot of information except on the really big cases. Also, the public feels strongly about its right to privacy, and this may affect the quality of underwriting information obtainable in the future.

Perhaps there will be a breakthrough in medical technology which will allow us to use a better measure of the aging process. I know there is a lot going on in this area. Demographics and improving mortality tell us we will have a larger proportion of older insureds to underwrite. The classic measures of build and blood pressure just will not be enough.

However, life insurance risk classification will continue to be possible in the future only if we can convince the public that what we are doing is in its best interest!

MR. COURTLAND C. SMITH: John Cook has outlined some changes in the historic environment of the life insurance underwriter. He has emphasized the multiple and often conflicting demands of various pressure groups. These demands have changed the underwriter's job from a concern for security to a need to walk a tightrope. Today, legislators, insurance departments, consumerists, and insurance salesmen have a larger voice in the underwriter's working life than in the past.

Mike Cowell has described the fundamental rationale for recognizing differences in age and other significant risk variables in a free competitive market environment. When some risks are overcharged, competing insurers act to attract them away. In attracting risks, insurers may produce increasing refinement in rating classifications up to a point of diminishing returns. Mike mentioned the historic adaptability of the life insurance industry. He suggested we give thought to developing a risk classification system based on biological age as inferred from individual life expectancy estimates. Of course, the present value of any anticipated extra mortality depends partly on its incidence by duration. Mike's thought reminds me of the Swedish system of pricing for constellations of impairments by using both adjustment in age and flat extra premiums.

Linda Emory has discussed the 1980 MAP Survey findings. These findings point to increased public resistance to the use in risk classification of sex, marital status and physical handicaps that are outside the control of the insured. Linda mentioned The University of Chicago Law Review article on "Sex Discrimination in Insurance". This article attempted to account for mortality differentials between the sexes on the basis of differences in behavior such as smoking, drinking, reckless driving and Type A work habits among men. Linda's thought is that we may have to abandon separate rates by

sex and substitute personality type as a factor in rating if studies should substantiate such a change. If indeed women are becoming more aggressive and career oriented, is their mortality in fact beginning to approach male levels?

The 1973 Reports Number of the Transactions (page 225) contained a brief survey on mortality differentials by sex. The U.S. general population figures cited there showed a distinct differential in life expectancy that favored women and was widening. The statistics were similar for standard insured lives. Insured female mortality rates were observed to be lower than male rates in each age group, averaging about 60 percent of the male rates for all ages combined. For life annuitants the pattern was similar. Female mortality rates averaged about 55% of the male rates in the first ten contract years and 80% of the male rates in years 11 and over. Of course, there were company variations in the sex differentials both for the insured and for the annuitant experience.

The 1979 Reports Number shows broadly comparable results. The female rates are generally less than the male rates in each issue age group, averaging 63.5% of the male rates for standard medical issues in the first 15 years, 57% for standard select nonmedical issues and 62% for the ultimate issues. The female nonrefund annuitant rates continue to be lower than the male rates and to be improving at a generally faster pace, especially in the first 5 contract years. There are some surprisingly high mortality ratios for female medical issues at issue ages 25-34. Nevertheless, the case for broadly and inevitably converging mortality by sex is not clearly supported by the statistics we have in hand.

It seems to me we should let the statistics and the free market continue to speak for themselves. Females generally enjoy lower mortality than males; their accidental death rates are lower, but their sickness disability rates are higher. As a result, most insurance companies charge women less for life insurance and auto insurance at the younger ages, but more for annuities and health insurance. If sex differentials are going to be smaller in the future, the statistics should reveal that fact. And if most companies should choose to ignore that emerging reality, they will do so at their own competitive peril. There will almost certainly be smaller companies around that are quite willing to target on over-priced risks.

Underwriting is a complex art. It involves statistics, stereotyping, risk-taking and selling. Statistics provide a necessary and useful guide. Governmental strictures may be needed to protect rights of privacy and to prevent forms of discrimination judged to be contrary to public policy, such as racial discrimination. However, we seem well-advised to follow the ACLI lead in advising legislators and regulators to move slowly and carefully in legislating socioeconomic change. In the early 1960's New York outlawed underwriting distinctions on racial grounds. As a result, virtually no mortality data by race have been available on new risks since about 1964. By the early 1970's, it had become impossible to provide the federal government with any volume of industry data to support or refute existing notions of the continuing mortality disadvantages of the nonwhite population.

Statistics may be a guide, but they are not enough. Underwriting also involves a certain stereotyping - a visualizing of the risk, his environment and mode of living. Such a visualizing of the risk can be helpful to the underwriter but it can also be misleading. Charlie Will likes to speak of bartenders, who as a class, may qualify statistically for an extra premium

of \$5 per \$1000. However, there may be an individual bartender who works at the Waldorf from 11:00 A.M. to 7:00 P.M., takes the commuter special, lives a normal family life and qualifies for a standard rating. And on the other hand, there may be a bartender who works at a small bar in the Bowery till three in the morning, drinks along with his customers and rates a solid extra of \$15 per \$1000. The visualizing may require some individualizing if justice and good business are to be done.

Underwriting includes risk taking in the broadest sense. If underwriting involves avoiding the most blatant antiselection and securing reasonably consistent classification of risks, it also involves trying to secure an average to better than average mix of risks for each class. Furthermore, underwriting involves making the occasional business decision needed to obtain a whole case. In other words, underwriting in today's competitive environment involves selling; i.e. backing the agent in order to obtain a sufficient volume of risks to secure reasonable experience averaging.

Can we do without differentials by sex or marital status or physical handicaps? Of course we can. But should we have to? Why should we not have the freedom to take these categories into account in life and casualty underwriting until the statistics and the marketplace tell us we are wrong to do so?

It is our freedom, and we shall have no one to blame but ourselves if we lose it.