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UNDERWRITING

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1. Problems with traditional underwriting classification: privacy, disclosure, antidiscrimination, etc.

2. New and acceptable classifications: smokers, lifestyle, build, blood pressure, finances etc.

3. Possible transition problems: existing policies, persistency, coordination of previous data with newer classes, etc.

MR. CHARLES N. WALKER: Like everything else in the insurance business, underwriting is a constantly changing affair. It continues to be a fascinating blend of science and art, but the techniques of mortality and morbidity are evolving and, we think, improving. Of late, the legislators are injecting themselves into what used to be an obscure process. They have begun to require that we explain more about ourselves. Therefore, our purpose this morning is to discuss some of the problems and developments which are currently commanding the attention of underwriters, whether they are actuaries or not. In doing so, we want to focus on recent developments rather than long term issues or problems of 10 or 20 years hence.

The first item on your program refers to traditional underwriting classifications as related to privacy, disclosure and discrimination. Recent and pending legislation is an important part of this. In the United States, there have been a number of recent enactments and proposals with potential impact on underwriting classification methods. A growing concern about the advances in computer technology in the 1960's and 1970's led to a number of Federal proposals on privacy protection which culminated in the Federal Privacy Act of 1974. This Act applied only to governmental handling of personal information, but it also established a Privacy Commission to study needs with respect to private industry. This Commission's report in 1977 made a large number of legislative recommendations, including one group pertaining to the insurance industry. Several Federal bills were introduced in the 96th Congress, including one sponsored by the Carter adminstration. Hearings were held, but time ran out; so nothing was enacted.

The change in administrations has altered the situation. This is not so much a matter of partisan politics as it is of priorities. Both parties have privacy advocates. The Republicans' current attention is on other issues -- economics, inflation and defense -- and privacy has been supplanted by these and become quiescent. One bill has been introduced, but there is little prospect of action in the 97th Congress.

The situation is different at the State level. While it would be unfair to suggest that State activity was triggered by Federal interest, it would be safe to say it was accelerated by it. After a several year drafting effort, the NAIC adopted a Model Act on Privacy in 1979 (which was amended somewhat in 1980). As of now, it has been enacted in five states: Illinois,

California, Virginia, Montana and Arizona and part of it has been enacted in Kansas. There are likely to be several more enactments yet this year.

This law affects many aspects of company operations. The most important affect on underwriting include (a) a greatly expanded notice of information practices, (b) an expanded and more detailed authorization form, (c) mandatory disclosure of reasons for adverse underwriting actions, together with supporting information, and (d) policyholders' access to information collected about them, with an opportunity to request corrections and amendments.

Paralleling the activity on privacy is a considerable amount of activity, nearly all at the State level, aimed at protecting the confidentiality of medical information. Very little, if any, of this is aimed directly at the insurance industry, but there is concern that some of it may, at least inadvertently, interfere with our access to medical records.

A somewhat independent area of legislative and regulatory activity in the United States is that involving discrimination. Two different areas are notable: sex and the handicapped. Following the Manhart decision, several Federal bills have been in front of both the 96th and 97th Congresses which would prohibit pricing differentials by sex. Similar bills have started to appear in State legislatures. This is a huge topic which we do not propose to discuss today.

Legislation concerning the handicapped is a different matter. There are laws in well over half the states. Most follow the NAIC Model Act, but there are seven atypical versions. There is, however, a great deal of variation from state to state in the definition of handicapped.

The legislative and regulatory situation in Canada has both similarities with and differences from the United States. Since Jim Saunders is more familiar with it, I will defer to him.

My purpose in reviewing this legislation is to note for you that it requires your current attention, and it does have an affect on both current and future underwriting practices. There is more involved than a response to legislation, however. Market forces are also at work which have an influence. Some of this is caused by external developments; some is not.

The United States Surgeon General's reports have focused the public's attention on smoking as a mortality hazard. This has been reinforced by publication of insurance experiences by State Mutual and others.

Public attention and discussion of that elusive thing labeled "lifestyle" has also had an affect.

So let me stop and let your panelists get into a more fruitful discussion.

MR. W. J. SAUNDERS: Canadian actuaries, and especially those involved in underwriting, rate making and employee benefit plan design, find human rights legislation having more and more impact on their work. Ten years ago broad exemptions for insurance coverages and employee benefit plans would be found in the legislation. Then attention was drawn to pensions and group insurance plans as part of the employment process and quidelines were developed to prohibit certain practices and features of such plans as discrimin-

atory. More recently, increasing attention is being focused on features of individual insurance contracts which are deemed to be discriminatory.

The legislative and regulatory environment in Canada is, however, a rather confusing scene. We have provincial legislation, federal legislation and a proposal before the Federal Parliament that we have a Charter of Rights and Freedoms in a patriated Constitution. We also have, currently, a number of discussion papers that have been prepared by government-appointed committees, both federal and provincial, that could lead to revised or additional legislation. First, a few words on legislation.

The Federal legislation is the Canadian Human Rights Act. It applies to all Federal government departments and agencies, crown corporations and to business and industry under Federal jurisdiction, such as banks, airlines and railway companies.

This legislation was passed by the Federal Parliament in July, 1977, and lists nine prohibited grounds for discrimination that include age and sex. Benefit Regulations for this Act came into effect on March 1, 1980. The major cause for concern is the prohibition in the Regulations against money purchase plans with sex-differentiated benefits. The Canadian Life and Health Insurance Association has urged the Commission to reconsider this prohibition. However, the arguments advanced by the Association were rejected. At this point in time, all is quiet. There does not appear to be any attempt to comply. No complaint has been lodged.

If the Canadian Human Rights Act, which is Federal legislation, does not apply, then provincial legislation has jurisdiction; and as suggested earlier, the legislation is anything but consistent in content and applicability from province to province. All provinces have legislation.

The scene in our eastern provinces is fairly quiet. In only two of the four is there any activity that relates to the insurance industry.

Nova Scotia legislation prohibits discrimination because of sex, and only recently was a complaint registered by a female because she was quoted a higher premium than a male for income replacement insurance.

New Brunswick does not prohibit discrimination with regard to individual insurance contracts, but does prohibit mandatory retirement. However, as noted recently in the report of a one-man Commission appointed by the government, everyone is ignoring the legislation, and it has been suggested that the legislation should be either changed or enforced.

In Quebec, the Superintendent of Insurance recently requested that a extensive questionnaire regarding companies' practices with regard to coverages for women be completed. The purposed of the exercise is not clear.

However, the Superintendent recently provided the Canadian Life and Health Insurance Association with an advance copy of their compilation of the survey and invited comments of the Association before the results are released. There is some indication of differing interpretations by respondents, and although the results appear to be generally satisfactory, the Association intends to seek an audience with the Superintendent to discuss some of the answers as well as the positive features of the survey.

In Manitoba, currently, mandatory retirement is a big issue. It is expected

that regulations regarding employee benefit plans will soon be finalized and that their attention will then turn to individual insurance contracts.

In Saskatchewan, Human Rights Legislation was revised about two years ago. Under the revised legislation, coverage under income replacement plans would have to include maternity-related absences. The industry expressed its concerns and a firm of employee benefit consultants was asked to review and report on what should be done. The industry has been advised by Saskatchewan officials that draft regulations are being prepared and will soon be available to the industry for review and comment.

The most publicized complaint under human rights legislation in Canada on which a Board of Inquiry has ruled is the Cairns case in Alberta. In 1975, a Ms. Cairns alleged discrimination as annuity income for herself was lower than it would have been if she had been a male of the same age. In 1979, the Board ruled that there was a violation of the Act by the insurance company. However, it also stated that damage done did not warrant financial compensation and questioned whether the Insurance Act should not be amended to provide an exemption for this legislation. The government did set up a committee to review but no one, including the Human Rights Commission, knows what is happening or might happen.

In British Columbia, there cannot be discrimination with respect to an accommodation, service or facility customarily available to the public unless reasonable cause exists for discrimination. In 1977, a court decided that insurance was a service customarily available to the public and, therefore, subject to the Act. Two complaints concerning underwriting of insurance have been lodged.

The following excerpt from the B. C. Throne Speech of December, 1980, will illustrate the keen interest that the legislators in B. C. have in human rights legislation:

> "Next year has been proclaimed International Year of the Handicapped by the United Nations. During 1981, my government, under the direction of my Minister of Education, will initiate regulations pursuant to certain sections of the Human Rights Code of British Columbia to specify a handicap as a characteristic in which discrimination in services, facilities, accommodation and employment are unequivocally prohibited".

If discrimination on the basis of handicapped is "unequivocally prohibited", insurance underwriting on the basis of health could be "unequivocally prohibited". However, at this point in 1981, no such bill has been introduced in Parliament.

In Ontario, legislation has just been introduced that would revise the Human Rights Code. The proposed code would prohibit discrimination because of a number of circumstances including sex, age, marital status, family or handicap unless the distinction, exclusion or preference is made on bona fide and reasonable grounds.

Should we take comfort from the fact that British Columbia allows discrimination if there are bona fide and reasonable grounds? Perhaps, but let us remember that this type of legislation could make the Human Right Commission, a Board of Inquiry or the Courts the underwriter of last resort

if we cannot statistically support our position. We will have non-experts in underwriting and rate making coming up with judgmental decisions that could have substantial financial impact on the industry and yet will bear no accountability for such decisions. As you can see, provincial human rights legislation is a mixed bag. The emphasis or thrust of legislation varies from province to province with little apparent impact on the insurance industry in some provinces. Needless to say, there is a certain amount of uncertainty as to what may be expected.

As noted earlier, at the Federal level, the government is proposing that there be patriation of our Constitution with a Charter of Rights and Freedoms being part of the package. As currently drafted, this charter establishes equality before the law and equal protection of the law without discrimination because of race, national or ethnic origin, color, religion or sex.

The Canadian Life and Health Insurance Association (CLHIA) wrote to the Minister of Justice expressing its concern that a broad interpretation of this provision might prohibit the companies from charging premium rates for life insurance and annuity contracts that varied because of age or sex. The Minister responded stating that, in his opinion, our concerns were unfounded if the distinctions are based on justifiable differences. Even though his response is reassuring, there are doors that have been left open and with so many pressure groups, logic may not prevail.

In the area of privacy, seven of the ten provinces have legislation dealing with consumer investigative reports with the legislation being similar to that of the Fair Credit Reporting Act of the United States. Although no two acts are exactly the same, there is essentially little difference and most companies have adopted practices for all provinces along the lines of the most stringent. Indeed, most companies employ the same procedures in all provinces, including the provinces of Alberta, New Brunswick and Newfoundland that do not have any such legislation.

And now a few comments are in order on the more important special reports that have been prepared by government-appointed committees.

First, at the Federal level, there is the Report of the Special Committee on the Disabled and the Handicapped. The Committee was made up of seven members of the Federal Parliament and had a support staff of 23. Hearings were held across Canada, and more than 600 briefs from individuals or organizations were received. The Report of the Committee contained 130 recommendations in 20 broad areas such as employment, education, income, access to public buildings, human and civil rights, etc. Their wide-ranging recommendations are general in nature. However, two recommendations should be noted: (1) that there be a shifting onus of proof so that once the complainant has made a reasonably believable or reasonably sound case of discriminatory practice, the onus of proof shifts to the respondent to prove that discriminatory practices did not occur; (2) that a comprehensive disability insurance program be established, intergrated with the Canada Pension Plan (CPP) and the Quebec Pension Plan (QPP), cover all disabled employees, spouses and dependents, be indexed to the CPI and be paid for out of an expanded premium structure and CPP and QPP.

At the provincial level, and in Ontario, a Select Committee on Company Law, comprised of approximately 14 members of the Provincial Parliament, has spent the last three years studying the insurance industry. Currently, they

are looking at A & S. Previously they had studied and reported on the life insurance industry and general insurance business. A number of industry groups appeared before the Ontario Select Committee, including the Canadian Institute of Actuaries.

The Report on Life Insurance of the Ontario Select Committee on Company Law was published in June, 1980. The Report ran to 500 pages and included many recommendations. The recommendations do not indicate any areas of immediate and pressing concern, and the Report is not expected to lead to wholesale amendments or additions to Statutes or Regulations. The industry hopes for a free and open discussion of this Report with government officials and certainly will want to comment on certain recommendations. For example, the Report recommends: 1) that the industry reduce the role of judgement in underwriting, while many of us feel it should be increased and 2) that the actively-at-work requirement be eliminated as a general condition of eligibility for group coverage which would certainly lead to selection and increased costs.

Also, in Ontario, we have the recently issued Report of the Royal Commission on the Confidentiality of Health Records. This Royal Commission was established by the Government of Ontario to address concerns about so-called unauthorized obtaining of medical information. Representatives of some insurance companies were called upon to appear as were officers of the MIB. CLHIA also filed a submission on the activities of member companies and their need for medical information in connection with underwriting and claims. In addition, a set of guidelines respecting privacy, that had been developed by the Association, was filed. The Report of the Royal Commission was issued in February. It commented favorably on the activiites of the MIB and the Association's privacy guidelines.

One aspect of the Report that may be of concern is a recommendation regarding the authorization for the release of medical information. A committee of the CLHIA will be studying this recommendation with a view to making any representation necessary to ensure that our hands are not completely tied and the necessary information can be obtained.

Now, let me turn to one of the other topics to be covered by this panel: non-smokers' risk classification.

In Canada, we have been much slower in more fully recognizing the mortality differences between smokers and non-smokers than has been the case in the United States. Prior to two years ago, and except for one or two of the smaller companies, the smoking habits of Canadians were only a consideration in assessing the extra mortality on a substandard risk.

During the last two years, and especially in the last few months, most major companies in Canada have started marketing policies that have a lower premium if the life to be insured is a non-smoker.

In order to qualify for non-smoker rates, the only requirement in most companies is that the individual not have smoked any cigarettes during the past twelve months. In a few companies, there are additional requirements with respect to height and weight and family history. In two or three companies, an additional reduction in premium is allowed if the life to be insured is judged to be a preferred risk on the basis of coronary risk profile.

The fact that most companies were inclined to quickly follow the lead of the major companies that introduced and promoted non-smoker policies can certainly be appreciated. Those companies that had not moved from the traditional approach of aggregate rates for smokers and non-smokers found that their premiums were not competitive on non-smokers and more than competitive on smoking, especially on term plans where differences in mortality assumptions are most obvious. A survey of term cases by one company, just prior to the introduction of non-smoker rates, revealed that nearly 80% of the applications were non-smokers.

There are many questions that must be answered as a company moves into smoker and non-smoker policies, and the questions are not always easy to answer, and perhaps the answers are not necessarily the same for all companies.

Let me outline what I believe to be some of the more important questions.

1. What about inforce policies?

   -does a company have any moral obligation to do anything for its policyholders?

   -should policyholders be advised that they may be able to qualify for better premium rates? If you do not do it, will the agent of another company do it?

   -how much evidence is required in order to qualify a policyholder?

   -can you afford to do anything; i.e., can you afford to do anything but try and conserve this older business on premium rates that are profitable to the company?

2. Do you offer non-smoker discounts on a limited number of plans or on your entire product portfolio?

   -can you justify not doing it for every plan?

   -can you afford to limit the discount to a few plans; i.e., if you limit your non-smoker policies to renewable term, cannot the smoker select against you by applying for a term policy on which you are still using aggregate rates?

3. How do you treat the non-smoker who is substandard?

   -This individual will expect to see some tangible evidence that non-smoking is recognized in the premium. However, if he receives a dollar and cents reduction in the basic premium, the assessment of the overall mortality rating must suffer.

4. What premium rate is a non-smoking policyholder entitled to on a new policy that is issued under a Guaranteed Insurability Benefit or as a Term Conversion if:

   (a) the original policy was issued on aggregate rates?

   (b) the original policy was issued with non-smoker premium rates?

-What about Group Conversions?

5. What is your philosophy or practice if you determine, after issue, that the smoking question in your application was answered incorrectly?

-is a stance that states that the policy will be void from issue on the basis of misrepresentation, or fraud, too severe?

-should you use a more moderate approach, such as an adjustment to the amount similar to that for a misstatement of age?

-does this less severe approach lead to problems?

-how much does the individual have to lose by misrepresenting his answer?

MR. ALLAN R. JOHNSON: One of the topics I have been asked to cover this morning is shown as Number 1 in the program - Problems With Traditional Underwriting Classification: Privacy, Disclosure, Antidiscrimination, etc. The dictionary defines tradition as "the knowledge, doctrines, customs, practices, etc., transmitted from generation to generation". That same dictionary defined a generation as covering a period of approximately 30 years. Therefore, since I have been in the Underwriting Department at Metropolitan for far less than 30 years, I cannot speak authoritatively about underwriting tradition. However, I can speak on what Metropolitan and, perhaps, what the industry as a whole was doing in the United States ten or twelve years ago.

Applications were solicited then not too differently from today, at least in our company. The representative completed an application and told the customer that in a short period of time he or she would return with the policy if the customer qualified. Approximately 97 percent of the time the representative did, in fact, return with a policy. As for the 3 percent we declined, I do not know what they told them or how they answered questions about the reasons for the decision to decline. For approximately 6 percent of the 97 percent we issued, the representative returned with a policy issued with an extra premium. Except for policies rated for build, we did not tell our representative or the customer specifically why that extra premium was necessary. We did, however, give our representative a very general reason, for example, medical history, or medical findings.

However, if the reason was because of information in a consumer report, we did not say so. We said that we could not discuss the reason.

Viewed from today's perspective, this does not sound like a very good way to treat customers. Congress did not think so either, and as Chuck discussed, we were subjected first to the Fair Credit Reporting Act (FCRA) in 1971 which required us to prenotify our customer about the investigation and the type of information we would gather. It also required us to provide a postnotificaton of an adverse underwriting decision. Congress' concern did not end with FCRA. The Privacy Act of 1974 authorized the creation of the Privacy Protection Study Commission which, in turn, produced the much-discussed 17 recommendations affecting the insurance relationship.

Metropolitan, as I am sure most other companies did, studied the 17 recommendations carefully. For our part, we were pleased to see how reasonable most of them were. In some respects, they involved little more than an

extension of the Fair Credit Reporting Act. The recommendations called for notifying a person what we were going to do with the application, what type of information we would gather, what we would do with that information, and importantly, what disclosure we would make of the information without the individual's authorization. It also called for notification if we took an adverse underwriting action, provide the general reason for the action and an opportunity to review most of the information in our files. You can be sure we spent a good deal of time looking at how the I's were dotted and the T's were crossed because we had to concern ourselves with the possibility of unreasonable or unintended interpretations of the recommendations. Overall, though, our reaction was that the recommendations made good business sense. They called for our treating our customers the way we like to be treated when dealing with banks and other organizations.

Our corporate response was to voluntarily implement a privacy and disclosure program incorporating virtually all of the recommendations slightly modified to fit the operations of our company and the marketplace. They were in full keeping with the spirit, if not the substance, of the recommendations. Our objective was to show regulators and legislators a workable, effective privacy and disclosure program and to establish a "credibility base" from which to lobby.

We introduced our program in July, 1979, and not surprisingly, among our customers there was little, if any, adverse reaction. There was, however, adverse reaction from some of our sales representatives to our new practice of sending letters disclosing an adverse underwriting action and the reason directly to the customer. In most instances, it was because our letters, in the opinion of our sales associates, were not sufficiently marketing oriented. When I look at them in today's environment, they were quite right. Initially, we did not do much more than simply inform the customer of our decision and the general reason for it. We have since modified our letters a number of times, and we believe we are now in the position of being as communicative as possible in a friendly way and generating the least possible disruption in the sales process.

I must be frank, however, and admit that some of our representatives objected to our disclosure letters not because of the way they were worded but because they felt the letter would drive the customer into the welcoming arms of a competitor.

That reaction was strongest at the outset and has subsided now, perhaps due in large measure to our being able to demonstrate that there was no discernible increase in our "Not Taken" rate coincident with the implementation of the program. Some of our salespeople even tell us now that they are better able to place substandard insurance with the information we provide, which not only includes the general reason for the adverse decision, but where possible, the date when we will reconsider our decision.

Concerning discrimination, during this same decade United States companies were subjected to, and are still subject to, a variety of proposed laws concerning unfair discrimination against certain groups of the population, most notably the handicapped and the blind. Thanks to the efforts of our friends at ACLI and many other groups, most of the current bills seem reasonable in requiring, for example, that a company not decline or otherwise limit coverage solely due to a particular condition except where such limitation is made on the basis of sound actuarial or underwriting principles related to actual or reasonably anticipated experience. This

provides companies with the latitude to make free-market decisions about impairments disclosed on applications of their customers for insurance while, at the same time, providing reasonable protection to consumers against unfair discrimination.

This legislation did not occur spontaneously. It occurred because there were underwriting actions taken in the past which did not reflect actual risk but which seem to have been based on stereotypes. In this regard, we were no less guilty than anyone else. For example, we applied small rating to Life, Accidental Death, and if offered, the Disability Waiver Benefit on applications on blind persons to reflect what our previous generation of Underwriters and Actuaries viewed as a reasonable estimate of the increased accidental risk. The developing legislation forced us to look very closely at all our underwriting actions for blindness, deafness, and other handicaps. That review was geared to reviewing the appropriateness of charging an extra versus the traditional safe way of tacking on an extra if you are not sure.

I would pause here to say that the bills and legislation that we are now dealing with in the area of handicaps, as well as those on privacy and disclosure, were prompted by the traditional underwriting methods of the previous generation. In saying this, I am not criticizing nor condemning our predecessors. Their actions simply reflected society's attitude toward the handicapped, toward females, toward persons with "different" sexual preferences, and so on. Today's underwriting rules are not the products of particularly enlightened people; rather, they reflect today's demands for equal rights for all segments of society.

Earlier this month, at the Home Office Life Underwriters Association annual meeting, Barry Goldwater, Jr., United States Representative from California, discussed the roles of government and business. He, as many of you know, is a strong opponent of what he calls "excessive government". He believes that government should limit itself to that which only government can do, such as provide for the national defense, control crime and deliver the mail.

On the other hand, he also said "Congress has ears", and I gather that remark should apply to Parliament. That was not a threat; it was to imply a statement of fact. Eventually, the will of the people will be exercised. If private enterprise, for example, fails to treat the public in the way the public believes it should be treated, government, like nature, abhoring a vacuum, will fill the breach. Business will then be conducted the way government believes it should be conducted which ample experience shows is usually not in the best long term interests of either the buyer or the seller.

In summary, I believe the 1980's will provide great challenges to Actuaries and Underwriters in dealing, not only with the new products and marketing methods we have been hearing about these past two days, but also in dealing with our customers in a way that will be mutually profitable. The right to be free of "excessive government" is one which must be earned, and like the Eastern Airlines slogan, "We have to earn our wings every day", so must we earn our right every day to fly free of "excessive government".

MR. MICHAEL J. RICH: Those of you who have been involved with underwriting over the last few years are well aware of the changes that have taken place. We have seen changes come about over the last several years from numerous forces, such as:

-regulations which have restricted our ability to deny insurance;

-restrictions placed on the ability of third party suppliers to gather information;

-high inflation which has increased underwriting cost, thus limiting the amount of information we can afford to obtain;

-various regulations that have caused a significant increase in paper work for the underwriter.

All of these forces have two common characteristics. First, they all originated outside the insurance industry. Secondly, they all have much the same impact on all companies. Not all major changes we have seen have these two characteristics. In particular, the topic of my discussion today, new underwriting classifications, has not been forced by pressures from outside the insurance industry, and company reponses have been quite varied. My plan is to discuss first the atmosphere that led to the changes, then the reactions we have seen from different companies and finally where we might be heading in this area.

First, turn back the clock to the 1960's. For the most part companies simply issued policies on a standard basis or in one of the roughly dozen substandard classes depending on the number of negative health factors involved. There was no incentive to be any more imaginative. However, two factors changed that situation in the early to mid-1970's that pressured companies into altering their position. The first of these factors was in the spotlight that was placed on price comparisons. Applicants became more and more concerned about how much they were paying for their insurance. It became quite common for a sophisticated buyer to shop around to several companies. This situation left many companies with only two alternatives in order to become more competitive. Those two alternatives were either to cut the margins in their premiums or to find a method to classify the better risks so they could offer lowered premiums.

At about the same time, and somewhat related to the increased competitiveness, companies began to turn more to reinsurance shopping. Meanwhile, the reinsurers had introduced innovations which allowed them to quote lower ratings on those risks they felt would exhibit lower mortality. The direct writers were then faced with the dilemma of how much business they could afford to give to the reinsurers. For many companies the answer was either to shop less, and face the wrath of the field force, or to adopt some of the reinsurers' procedures.

Although the problems just described were faced by a significant number of companies, the solutions chosen were quite varied. In order to describe some of the approaches taken, I would like to break them into two categories. These two categories I will call "marketing oriented" and "underwriting oriented". The marketing oriented are simply those approaches which are readily apparent to the applicant. In most cases the agent would have sold the policy on the assumption that the applicant would qualify for the special classification. For example, a non-smoker classification would clearly fall in the category of marketing oriented. The underwriting oriented approach would have the exact opposite characteristics. This approach would not be apparent to either the applicant or the agent. It would involve offsetting underwriting debits with underwriting credits for certain factors in order to be able to make better offers to the better

mortality risks. For example, giving underwriting credits for being a non-smoker would clearly fall in the category of underwriting oriented.

The exact number of companies which have instituted the marketing oriented approach is not known. However, it is obvious that the use of this approach has grown significantly over the last few years. Although many of these companies have used the term "preferred" to represent their special classification, the similarities end there. In order to describe some of the approaches within the time constraints, I will discuss the approaches in three broad categories. Those categories are non-smoker classification, non-smoker classification with other qualifications, and preferred risk plans.

1) Non-smoker's classification - A few companies had a non-smoker's classification as far back as 10 or 15 years ago. However, the general view taken by most companies at that time was that this approach was simply a gimmick. This attitude was probably based on the fact that there was little solid data supporting the mortality improvement due to not smoking. Since that time we have seen the release of both the Surgeon General's Report and the State Mutual Report. When these studies were released, they received a great deal of publicity. This made it very difficult for us as actuaries to deny either the significance of smoking status on mortality, or the reasonableness of giving lower premiums to non-smokers. Once some of the major companies introduced a non-smoker classification, it became extremely difficult for other companies not to follow suit. Any company that does have now, or plans to have, a non-smoker classification will run the risk of increasing the proportion of smokers they plan on the books. This result can only have a negative impact on mortality. At the risk of stereotyping non-smoker classifications, I would like to go through some of the major characteristics of the plans that have been adopted:

    a) Despite the potential problem with replacements, non-smoker discounts cannot be given to policies placed on the books prior to the introduction of the non-smokers classification. Otherwise, the risk exists that the remaining class of inforce lives will exhibit mortality that may not be supported by the premiums.

    b) Smoking is usually restricted to cigarette smoking within the last year and excludes pipes and cigars.

    c) Since information regarding non-smoking status on juveniles would probably be of questionable value, the non-smoker classification usually starts at about age 20.

    d) The premium differentials currently being given are usually less than would be supported by either the Surgeon General's Report or the State Mutual Report. This position seems quite reasonable,

especially in light of the potential impact low tar cigarettes could have.

e) For those companies on a banded premium system, the discount is usually restricted to the highest amount bands. The justification is generally one of expenses.

f) The discount may or may not apply to substandard issues. My opinion is that it should apply to substandard issues to avoid the double negative impact on the agent trying to deliver a policy that has lost both its standard and non-smoker classifications.

It is worth noting that the original fear that everyone would simply lie and say they are non-smokers has not occurred. Most of the companies I have heard from are quite satisfied with the results they have seen to date.

2) Non-smoker classification with other qualifications - The most common example of this type is a non-smoker/build classification. In general, companies require that in addition to being a non-smoker, the applicant must have a height and weight that qualifies for standard insurance. This approach will tend to lower the percentage that will qualify from about 65-70% for non-smoker only to about 50-60% for non-smoker/build. If the purpose of this approach is to reduce the number of applicants that qualify, then it is quite reasonable. However, if the purpose is to significantly improve the mortality experience of the group, then it is open to question. It is not clear that the extra factor of build, or any other factor, will significantly improve the mortality experience over that expected simply from a group of non-smokers. The only experience I am aware of involved a large company that originally issued a non-smoker/build classification. After reviewing the initial mortality experience, they switched to a non-smoker classification because the non-smoker/build group experienced mortality very close to that exhibited by the non-smoker only group.

3) Preferred Risk Plans - This approach differs from the other two in that there are usually no specific predefined characteristics that must be met. The easiest application of this approach is to define your qualifications for preferred with tighter underwriting requirements than required for standard insurance. For example, you might define an applicant as eligible for preferred risk if there are no more than 10 debits versus the usual 25 for standard. The interesting aspect of this approach is that it is possible to have a non-smoker or non-smoker/build classification on top of a set of preferred plans.

As mentioned earlier, the underwriting oriented approach received its main impetus from the reinsurers. For years companies used the approach that everyone was standard and then added debits as various negative health factors were uncovered. The reinsurers took that approach one step further by saying that if negative health factors are bad, there must also be offsetting positive health factors. The list of positive factors that are currently considered is quite long. It might be of interest to briefly discuss two of the most significant ones.

1) Non-smoking - The mortality significance of non-smoking is, of course, the same as it is in giving a non-smoker classification. Obviously, you cannot give credits for non-smoking and have a non-smoker's discount unless you have not recognized all of the expected mortality improvement in the non-smoker's discount.

2) Low Blood Pressure - The fact that mortality increases with increasing level of blood pressure has been recognized in our studies for years. However, almost unnoticed is the fact that these same studies have shown that mortality improves as the blood pressure level decreases. For example, the latest blood pressure study shows that about 120/80 or lower exhibits mortality roughly 40% below that exhibited by 140/90.

There are, of course, many more factors which different companies recognize, and I have made it sound very easy to implement this approach. There are many considerations that must be taken into account. First, if your existing program does not include credits and your mortality experience is about as expected, problems could be created by simply implementing a new program. For example, if you suddenly introduce credits for non-smoking without any other change, all you will be doing is issuing the same policies and, therefore, the same expected mortality, but with a lower expected premium income. There are obviously two solutions. You can either base the substandard premiums on smoker's mortality or give debits for smokers. Another area that must be considered is how many credits you will allow to accumulate to offset the debits. For example, is it reasonable for a person with a serious heart problem, but a significant number of credits, to end up with a standard issue? I believe it is not proper. By compounding the credit you are probably duplicating the expected mortality improvement many times over. A reasonable solution would seem to be to limit the total number of credits given. A possible approach is not to allow the credits to reduce the rating by more than a certain number of rating classes. It should also be understood that, unlike the marketing approach, the underwriting approach will not produce a super select mortality group, nor will it do anything for a policy that has been rated standard.

Although it is usually difficult to predict the future, in the case of underwriting classification we can make some educated guesses. First we should look back at the causes. It seems highly unlikely that the pressures from price competition will lessen. Also, with the growth of non-smoker type classifications, it will become more difficult for companies without a non-smoker classification to compete. Therefore, it seems reasonable that we will see a continued growth of companies introducing some form of non-smoker's classification. The same conclusion can be drawn about the underwriting approach. It is going to be very difficult for companies to turn back the clock on reinsurance shopping. This is especially true when you consider that the agents are becoming more and more knowledgeable about reinsurance. The only way companies can reasonably stem this trend is to adopt some of the same techniques as used by the reinsurers. However, it is up to us as actuaries to keep a close eye on the mortality experience as it develops. We must be prepared to backtrack should it be proved that we have gone too far too fast.

MR. CARL MEIER: For some companies that reinsure and also write on a direct basis, there appears to be a difference in their underwriting of

a risk depending upon whether it came to them as direct business or as reinsurance. Could someone from a company who is in that situation comment.

MR. RICH: We have asked this question of our reinsurer. They tell us that the rate which they quote to us is identical to that of the other side of the house. Most of us realize that underwriting is not an exact science, and underwriters could reasonably arrive at difference ratings on the same applicant. Second, it may be that an underwriter involved in reinsurance has a different mindset than an underwriter involved with direct business.

MR. WALKER: One thing that is different between the reinsurance and the direct underwriters is reinsurance underwriters are insulated from the agent. That can make a difference. The reinsurance underwriter does not have to worry about the agent's reaction; so he is in a position to give you a purer risk appraisal.

MR. JOE E. DAVIS: On shopped cases you stated that ceding companies will have to adopt some of the practices of the reinsurers. Could you expand on that.

MR. RICH: There is no question that there is a great deal of concern by the ceding companies about the amount of business being placed with reinsurers. Although no one is forcing the ceding companies to shop, they are shopping a great deal to get the most competitive offer in order to place the business. It has almost gotten to the point where the agents expect it. When we have the agents come in, it is quite common to have the topic of reinsurance brought up. So, it is very difficult for companies to back off from the shopping that they are doing. If the goal is to continue to have competitive offers but give less business to the reinsurers, the solution is to adopt some of their approaches.

MR. DEWIGHT K. BARLETT: Mike mentioned that mortality improved with decreases in blood pressure. Where does that tend to reverse?

MR. RICH: I have been directly involved in the 1979 Blood Pressure study. Unlike build, where mortality studies have shown optimum weights for each height group, the blood pressure studies have shown no such pattern. The implication is that blood pressure cannot be too low. Obviously, there must exist some point at which too low a blood pressure is unhealthy; however, we simply have not been able to define it.

MS. LINDA MARIE SPRINGER: Since the percentage of non-smokers is much higher than that of smokers in the general population, do you see the non-smoker classification becoming the standard? Has your company or any other one looked at the inter-relationship between smoker-non-smoker factors and other risk classification factors (socio-economic, demographic). There is mention in the State Mutual Study that some of the mortality classes are not as homogeneous as originally thought.

MR. RICH: Unless you got to the point of saying that over 95% of the population were non-smokers, I doubt whether the non-smoker classification would become standard, mainly because there is a stigma attached to the idea of offering standard insurance. Your second question raises a very good point. We know that mortality improves as you go up the socio-economic scale. We also know, that most companies generally are giving this discount

for higher amounts. There seems to be duplication of mortality improvement here. I agree with the basic philosophy of non-smokers having better mortality. I am still somewhat skeptical that it is as significant a single factor as either the State Mutual's or Surgeon General's Reports would indicate.

MR. DALE GAMES: Regarding non-smoker, smoker rated policies, would you expect the same extra mortality on a Table D non-smoker and a Table D smoker for example?

MR. RICH: The question is, would you rather have somebody with emphysema who is a smoker or a non-smoker? Obviously, that is an extreme situation, but it makes the point. Given the choice between a person with a critical health problem, would you prefer they be a smoker or non-smoker? I think you would say that you prefer they be a non-smoker. There is a mortality difference there. How much, I do not know. But, there is something there, so you can justify different premiums. As I mentioned, not all companies have gone this route. In fact about one-half have not, and there are probably arguments on the other side.

MR. ALAN E. MORSON: What do you do as far as group conversions, term conversions or guaranteed insurability for non-smokers and smokers policy?

MR. RICH: What we did on term conversions is to go by the basis of the date of issue. In other words, if they are doing present day term conversion, the fact that they were a smoker or a non-smoker or not classified does not matter because they are coming in with a current issue policy on our current premium basis, and our current premium basis has smoker, non-smoker premiums. So, on our conversion application, we ask the question of whether or not they are a smoker or a non-smoker. In group conversions, we do not offer the non-smoker discount.

MR. WALKER: New England Life is doing the same thing as John Hancock on those two points. With respect to guaranteed insurability, what we are doing at New England is to qualify non-smokers the first time the insurability option is exercised. That then becomes a permanent qualification. So, the first option exercised for a non-smoking basis becomes a permanent future guarantee of non-smoking on future exercises.