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TRENDS IN UNDERWRITING

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Decreases in mortality and improvements in selection of risk techniques are being offset by increased lapse rates and selection costs. The panel will discuss current and anticipated responses including:

- o Simplified/guaranteed issue
- o Jet issue
- o Liberalized limits
- o New selection tools
- o Update programs
- o Underwriting for persistency

MR. HARRY A. WOODMAN: As I think we are all aware, the long-term trend has been to do less and less underwriting, particularly at ages forty-five and under. This is a result of trends in three of the factors that determine the cost of insurance (mortality, expense, and interest). Each of these trends is operating in a direction which makes it less profitable to underwrite. Mortality continues to go down, expenses continue to go up, and interest rates have been on a long-term rise, notwithstanding recent reductions.

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MR. ALLAN R. JOHNSON: I will be speaking on simplified or guaranteed issue, jet issue and liberalized limits. Part of liberalized limits will also include new underwriting tools.

In the early 1970s, Metropolitan developed a simplified underwriting approach in connection with the marketing of pension life insurance policies. Our requirements at that time were that if a case had five or more lives with participation and other requirements satisfied, we would issue up to $100,000 without any medical questions. Surprisingly, the mortality experience in that business was excellent.

Around 1980, in response to a perceived market need for employer-sponsored plans of permanent insurance which could be sold on a simplified enrollment, salary deduction basis, we developed a limited portfolio of products which provided for as much as $150,000, subject to a two-times salary limit. We did not have the same type of controls that we had on the pension product in terms of the amounts and participation requirements. We limited the numbers and types of riders to those essential to meet market needs so as to minimize our development and administrative expenses. Our pension experience made us confident that we could satisfactorily underwrite the mortality risk, but we were less confident of the lapse risk in light of reported experience of other companies who had pioneered in this market. We felt, however, that with proper group selection, competitive modern products, and a strong sales and support force, we could make this product work.

We ran a little contest on what to call the product. The boss won with Metromatic. For employee groups of three or more, the underwriting work-up was essentially simplified non-medical, and we called this Simplematic. Larger groups, typically 1,000 or more lives but occasionally as few as 500, depending on what we perceived to be the quality of the case, were eligible for the same limits but subject only to a tight actively-at-work question. We called this Issuematic. The Simplematic and Issuematic business has grown to 11% of all of our business in terms of number of applications, and we expect further growth in volume and improvement in bottom line results in the future.

We had some early problems with mortality because we failed to properly communicate our underwriting objectives and philosophy to our underwriters. That philosophy was to trade off a limited amount of underwriting expense dollars for claims dollars. We inadvertently created an impression that we would issue everything. A few early claims -- fortunately for small amounts -- quickly illustrated this chink in our armor. On an overall basis, our experience to date has been pretty much as priced on both the Simplematic and the Issuematic products. Our first-year lapse rate is quite satisfactory and within the levels priced for, but we have just recently seen higher than anticipated renewal lapse rates on our Simplematic product. The renewal lapse rates on the Issuematic product, which is typically sold to large groups which are carefully screened, involve more stable employee populations and produce satisfactory persistency. We are currently installing a conservation program for Simplematic, developed from the experience and suggestions of our sales people who have been successful in this market and successful in producing a book of business with high persistency.

The next topic is Jet Issue. The Metropolitan policy exhibit statement shows that the company issued 4.8 million policies in 1928. To handle that volume at that time, we had the "Approver" system, made up of clerical people who could be quickly trained to identify cases which needed no processing other than to prepare the case for the Issue Division. By the late 1960s, we developed a very sophisticated approval manual for our mix of business and were able to approve 60% of the business without having it go to an underwriter. We decentralized in the early 1970s, and the underwriting managers chose to do away with the "Approver system" in favor of staffing entirely with underwriters. To some extent, with pressures on expenses and availability of people, they are now moving back to an "Approver" approach.

Several years ago, our Canadian Head Office, a fully functional insurance company with its own computer center, allocated the resources necessary to modernize the underwriting environment. The Head Office's two objectives were to minimize handling and to minimize paper. It was understood that flowing from this would be electronic approval of clean cases. The project was headed by Pierre Olivier, FSA, who, en route to Fellowship, served as Underwriting and Issue Manager in the Canadian office. He worked closely with the incumbent

Underwriting Manager and with a Director in Electronics who had also spent several years in the Underwriting Manager's position. It was a totally user-developed project, and the fine results bear that out.

Within reason, everything that can be captured electronically is now part of the underwriter's electronic file. Each of our sales outlets enters all data necessary to administer the case, other than the classification. We have processing capability at the sales outlet level with appropriate edits being performed on site. Screens are called upon to expand on certain application responses. All communications with the Field Force are via electronic mail. All Attending Physician's Statements (APSs) and other requirements are ordered by the system. We expect to be receiving our investigative consumer reports via electronic mail in the not-too-distant future. The application, examinations, and reports from physicians are currently in hard copy form, but we look to the near future when image processing will enable us to capture these data and make them part of the electronic file. At that point, we will operate in a paperless environment which will generate substantial service improvements and clerical savings.

At the present time, we are approving between 5 and 15% of our applications without need of a Home Office employee to review the file. We expect that, as we introduce more screens, we will soon reach 40%. In the foreseeable future, we expect to be able to laser print policies at the sales outlet moments after the data have been entered, provided the case passes our approval screens.

The final topic is liberalized limits. I think every underwriter is aware of salespeople and areas where very little relevant underwriting information is provided on non-medical applications. Because of the limitations on data handling until very recently, this was part of life in the Underwriting Department. However, with increased computer capacities and the coincident reduction in costs, it is now possible to manage relevant underwriting information by using the computer to compare what we get to what we expect. For example, I would guess that most companies represented in this room have special underwriting remedies in certain areas where smoking seems to be rare by observation of applications but not at all rare when you visit that area. We had that

problem when we introduced the nonsmoker classification in 1981. Upon further study, we found that not only were we not identifying smokers, but other significant underwriting factors were not being recorded to the extent one would expect.

Our response to this was to develop a database which tracked yes or no responses to several key question groups on our non-medical applications. After we had accumulated a sufficient number of cases, we developed frequency curves which served to calculate the amount of information we should expect on a particular application. We compared expected information to what we actually got and developed weighted ratios of actual to expected for each of our Sales Representatives for whom we had a sufficient number of applications. We then ranked our Sales Representatives in three broad groups according to those weighted averages. We performed a mortality study of business produced by these Sales Representatives and found a significant and predictable variation in mortality. Those who provided the least information had the highest mortality.

We then began a year-long program of informing our Sales Force of our findings and our plans, which included varying underwriting limits according to the score of the individual salesperson. Earlier this year, an overwhelming proportion of our sales force had its non-medical limits approximately doubled and extended to higher ages than in the past. A smaller group was accorded even more favorable treatment. Similar extensions were made in our consumer report limits. We believe that our Sales Force is our best source of high-quality, low-cost underwriting information and that further management of its information-producing capabilities will enable us to generate improved mortality results while, at the same time, significantly reduce acquisition expenses.

We also asked our underwriters to code the findings of our underwriting requirements, paramedical and medical examinations, ECGs (electrocardiograms), APSs, etc. In addition to asking our underwriters to code a few objective findings of the particular requirements, we asked for their opinion as to whether the requirement was "of value." Having this information on our data base has significantly shortened the time and lessened the expense in doing "of

value" studies, since we have no need to review the very large percentage of cases where the particular requirement was of no value in reaching the final underwriting decision.

While we have had some difficulty in getting all underwriters around the country to consistently code "of value" correctly, the errors tend to be on the conservative side. As our underwriters get more training and experience in these analyses -- perhaps supported by our Electronically Assisted Underwriting System -- we expect to be able to perform ongoing "of value" studies without touching a paper file. Even further down the road, with the promise held out by expert systems or artificial intelligence technology, we believe that we will be able to use our data base to tailor make underwriting requirements specific to the particular individual, with application information captured at the site of sale via connection to the mainframe computer.

MR. HOWELL C. MARTYN: My remarks are called "Underwriting for Fun and Profit in the Late 80s" with the subtitle "Don't Lose the Forest for the Trees." My theme is simple: Collectively, our underwriting strategies today are counterproductive because they tend to be obstacles to getting new business.

I submit that putting and keeping new business on the books are fundamentally our only jobs. Remember that you heard that from an underwriter! In fact, I would state that the underwriting mission can be summarized as putting good business in force quickly, accurately and efficiently. This theme underlies all of the things that we ought to be thinking and talking about in the life insurance business. Look at each of the descriptions in that short statement:

- What does "good" mean? In that context, I interpret good as meaning well underwritten, and I think that, in general, underwriters spend 90% of their time on the underwriting aspect of new business and the industry results have generally been pretty good. I am frequently a little unnerved however, about what AIDS may mean in terms of streamlining the underwriting process.

- "Quickly" means quickly. Again, I think as an industry, we have done a better job than we have in the past about getting the business out. Mutual Benefit prides itself on getting more than 75% of its clean cases out within one week from the date we receive the policy to the date we mail it. That is a big turnaround from where the company was a year ago, but I have insurance competitors that can do that in forty-eight hours. Much more importantly, we have competitors in the financial services industry that can do that in five minutes by phone -- they are our real competition in the rest of the 1980s. That is related to the subject of market share, a term that has fallen in disfavor recently, but we cannot do without it. The competition for customers and for consumers' disposable dollars is going to get a lot tougher in the next few years. Good, fast time service is a key element in control of your customer base and new customers. As an industry, we still have a long way to go.

- "Accurately" means zero defects, in theory, but I assume we would be satisfied with something that approached 99% accuracy in the way we process new business and produce policies. Our underwriting strategies to achieve that are backwards. They put us into a you-me position. You as agents send in complete, accurate, legible applications, and we will issue policies correctly. How many of us use the GIGO (garbage in, garbage out) analogy in dealing with our agents? That is the wrong approach, because we forget that good salespeople are not complete, accurate, and legible people. If they were, they would be actuaries and underwriters. Do we really design our forms to achieve the results our companies want, which is good business in selective markets? Or do we design them for what underwriters or actuaries want? I am afraid I know the answer. What we need to do is to design application forms which achieve completeness, accuracy, and legibility as opposed to designing them for lawyers, underwriters, and actuaries who are clamoring for those things but do not produce the document that will achieve it. I will get back to that point a little bit later.

- "Efficiently" I think we all understand. That means cost-effective. Again, I think we do a better job in the industry on that than we used to but often for the wrong reasons. I will spend more of my time this

afternoon on the question of cost-effective underwriting systems but always within the context of putting new business in force and keeping it there.

I want to restate the new business mission in two other ways to oversimplify it. What we need to do is:

- o make it easy to get new business in (i.e., remove obstacles to selling);

- o get new business out (i.e., reduce processing time).

That is an oversimplification, but it leads us to a very important point. As competition forces margins down, premiums and commissions go down, too, and the need for sales goes up. Look what it does to the underlying presumption, that we all have that of an agent's responsibility is for accuracy, completeness, and legibility. When today's agents have virtually no time to learn about the niceties of underwriting, they are thrown into the fray essentially on a sink or swim basis. There is not time for teaching them all the niceties of our language, but does that stop us from talking about "evidence of insurability", "financial documentation", or "insurable interest?" We have a whole codex of terms that we have not outgrown and we expect those people in the field, with almost zero training, to understand and respond to it.

I will give you an example. I had a call from a young agent somewhere in the southwest. The agent had a serious problem with an old client and wanted to roll over all the cash value business that had accumulated in my company for many years into Universal Life. Unfortunately, the client has a severe insurability problem -- in fact, he was probably uninsurable. The question came up -- "What were the other options?" It became evident that the agent did not know what a cash value was. I decided to incorporate this in my talk because I think that is what we are dealing with. We are dealing with people, educated people, in good faith, who are trying to do the right thing. They have not had the time to get proper training. They do not understand the language, and they probably do not understand underwriting. They may not have the right application, and the applications they have are complicated, full of threatening terminology. Yet, we go out and say, "You do it right!" and then we will get

terminology. Yet, we go out and say, "You do it right!" and then we will get your product back to you. If we need underwriting information in today's world, we have to be prepared to get it ourselves and not call upon the agent to develop it for us. They cannot. They will not. It is not in their self-interest, among other things. They certainly have not been trained to do it.

This is one of the main rationales in today's marketplace for the phone history interview process. This is where trained people from underwriting departments are calling customers directly to get information on insurability rather than using the traditional third-party inspection report. It is a do-it-yourself process. It is faster. It is often more cost efficient, and I think that is the wave of the future. We should be doing that in far more areas than just as a replacement of the inspection report. For your average case, I think do-it-yourself underwriting is a necessity. For your very large case, from your sophisticated agent, you are going to have to negotiate with him or her as you always have, which is only appropriate.

We need to design underwriting systems that capitalize on the theory of large numbers rather than try to design rational underwriting models. We spend too much time trying to figure out how to balance the cost benefit of a non-medical limit with what everybody else in the industry is doing. Then we try to arrive at a rational idea of where you put your paramedical limits, your inspection limits, your specimen limits, your blood limits, etc. We have to make some decisions as to where our non-medical limits may be or exam limits or specimen limits, but that is not the objective. The objective is getting good business in quickly, accurately and efficiently. There is not just one big market out there. We often tend to think that way and have applications that treat the world that way.

Allan has described two or three methods that Metropolitan has which treat different markets differently. There are other ways to approach that and I will discuss a couple of them. They are not the same from company to company, and you ought to determine your marketing strategy before you make that decision. You do not have to ask the same questions on applications. If you do, you are going to get information on some cases that you do not need and you do not want.

As underwriters, we tend to think that it is a windfall when you get a piece of information that saves you from the $50,000 quick claim. You forget that the framework used to support that may be costing you $100,000 a year. What blinds you to the fact is you pay for that in two-bit increments, and you get seduced by the $50,000 quick savings. That is what is called "losing the forest for the trees."

Let me give you a couple of examples. On a million dollar case on a sixty-year old with health problems, you need an experienced underwriter who can develop all of the available information. The margins on a million dollar case at age sixty will support some pretty intensive underwriting investigation, but on a $25,000 case on a thirty-year old, what you need least is an underwriter looking for equity. Remember what your mission is. There is a caveat that goes with that. In today's environment of AIDS, I am a little queasy about that message. I am not about to abandon my approach, but I think there may be some qualifications that we need to address.

The last of our objectives is the question of efficiency. Consider the following example. An experienced Senior Underwriter spending all of his time looking at jumbo cases, complex cases, impaired risk cases, and reinsured cases should be able to handle 2000 cases a year. You are probably going to pay that Senior Underwriter $40,000. That averages to $20.00 a case for underwriter expertise. That number and the ones that follow are purely illustrative -- they do not illustrate what my company or any other company that I know does except by accident, but they do illustrate a very important principle. When we are confronted with a squeeze on our efficiency, we rationalize that if we can simplify our rules just a little bit, maybe we can get our Senior Underwriter to do 2500 cases a year and right away my unit cost has improved 25%. The Senior Underwriter only costs me $16.00 a case and I get pretty excited about that. That is wrong. Instead of walling off a section of our business and targeting the market expertise to the exigencies of that market, we are nickel and diming ourselves. We do not want to squeeze our underwriting requirements -- we want to squeeze the Senior Underwriter! We ought to make him more productive by taking away all the little cases he should not be doing in the first place.

Assume, in the next example, your company has 100,000 applications a year. Assume also that 75% of those are for amounts of less than $100,000 and under age forty-five. This is targeting a somewhat smaller case market. I think that all of us have a staff of underwriters with a hierarchy of job descriptions, career paths, approval limits, substandard limits, etc. We throw the applications at them, approximately 2000 a week, and assume that most of the little ones get down at the bottom and most of the big ones get on the top. We are all doing it that way, and we are all still here so it sort of works, but it is not the best way. Would you hire a consultant who advocated allocating work by the "trickle-up" method. Yes, you would! Most of us do. As Pogo once observed: "We have met the enemy and he is us."

On the other hand, if you took the 75,000 assumed clean cases and directed them to a department of people whose job was to put them in force as fast as possible, using a schedule of criteria that included only the major underwriting concerns, appropriate to younger ages, you would get the job done much faster. That kind of work would be done by people that we loosely call "data collectors", "record clerks", or "processing clerks." It may include policy issue functions or putting cases in force. There are lots of different options, but those people should not be underwriters. Those people should be trainable in four weeks. They should not be highly paid. They probably will turn over fast, but they will get that job done.

As Allan mentioned -- we have come full circle. We need to get back to that format because what we are talking about is the wheelbarrows full of small, simple applications. We have to get those out more efficiently than we do right now. Those 75,000 clean case applications can be processed by about fifteen people that are probably paid about half of what the Senior Underwriter is paid. In other words, $20,000 will get you 5000 or more applications approved instead of $40,000 which will get you 2000 or 2500 applications. Of course, the Senior Underwriter would not have done all those 75,000 cases, so I know the comparison is distorted, but he does too many of them because the "trickle-up" theory is alive and well in your underwriting ranks. You can drive your unit costs for 75% of your business down from something approaching $20 to something approaching $4. No matter how you qualify that, the direction is clear.

Some of you are already doing it, particularly in the biggest companies. Metropolitan is doing it, but most of us need to do more. Now my simplistic model conveniently overlooks the substantial difference in average case amounts and the relative difference in the quality of the risks themselves, but, unless your average case is a lot more than $100,000, then I suspect you are trickling up a whole a whole lot of cases in your underwriter or senior underwriter rank by osmosis. Ask yourself how many senior underwriters do you really need if they are only doing the kinds of cases they ostensibly are paid to do. Do not let referrals drive your productivity.

The following illustrations demonstrate what I mean and, again, all the numbers are totally imaginary. They illustrate a principle. I suspect that many shops have, out of twenty-five people in their underwriting ranks, four people who are called "Senior Underwriters", "Chief Underwriters", or some generic term that is your top production underwriting job. You are paying them probably $35,000, on the average and they will each underwrite 3000 cases (Illustration A). You have six underwriters and you pay them $30,000; they underwrite 3600 cases each. Overall, the twenty-five underwriter types are doing 103,000 applications a year.

On Illustration B, I show what I perceive to be a better arrangement. The two senior underwriters get a $5000 raise and do 500 fewer cases per year. Of the cases that they are paid to do -- the complex, the big, the reinsured, and the substandard -- their total costs will be $80,000. I left out one entire block, the associate underwriters. The bottom line is that a large number of underwriting specialists, not highly paid, do very large numbers of cases. Adopting that general picture, you can see what it does to your total underwriting picture. You have increased the number of applications by 1000. You decrease the total cost by more than $100,000. At every level, you have improved your underwriting career path. You have decreased your unit cost by about 17%, and there are some soft savings that would make it even more important. I guarantee that if you adopt something along these lines, you will improve your time service by approximately 50%. You will improve your communications with your field because the people who are paid to deal with the tough cases will not be spending their time with the cases they should not have been paying any

TYPICAL ARRANGEMENT TODAY

		Individual		Total	
		Cases	Salary	Cases	Salary
4	Senior Underwriters	3,000	$35,000	12,000	$140,000
6	Underwriters	3,600	30,000	21,600	180,000
7	Associate Underwriters	4,200	25,000	29,400	175,000
8	Assistant Underwriters	5,000	20,000	40,000	160,000
25				103,000	$655,000

average cost = $6.35

BETTER ARRANGEMENT TOMORROW

		Individual		Total	
		Cases	Salary	Cases	Salary
2	Senior Underwriters	2,000	$40,000	4,000	$ 80,000
3	Underwriters	3,000	35,000	9,000	105,000
4	Assistant Underwriters	4,000	25,000	16,000	100,000
15	Underwriting Specialists	5,000	17,500	75,000	262,500
24				104,000	$547,500

average cost = $5.25

ADVANTAGES

1 less person
1,000 more cases per year
Save $107,500 per year
Improve underwriting jobs/career path
Improve unit cost 17% ($1.10 per case)

attention to in the first place. They will have time to talk to the field, and they should be experienced in communicating with the field on those cases.

Allan Johnson's very interesting comments about the Metropolitan have triggered a couple of additional thoughts. I haven't mentioned automated or electronic underwriting as Allan described in some detail. That is not by accident. I have two quite different perspectives than Allan has. My company, Mutual Benefit, today writes about 50,000, going on 60,000, applications per year. Metropolitan writes approximately 600,000, going on 700,000, applications a year. I think the break even point for electronic underwriting or artificial intelligence is a lot closer to his end of the curve than it is to mine.

The second reason I say that is that at Connecticut Mutual I was instrumental a dozen years ago in putting in an on-line new business processing system which is still there. At my insistence at that time, logic was created to approve the simple small clean case automatically so that it was literally possible to achieve policy preparation, not actually mailing, within seconds from data entry if that case met all of the logic in the system. Now the problem was that, even though a few cases did come out and you got what we call an "auto-prove" within seconds, the time and cost of entering all of the data necessary to get that little trickle out and to keep up all the logic and to edit it far outweighed the cost and care of the feeding of the humanoid approvers. By eliminating a chunk of systems inputs and edits and adding staff, we succeeded in cutting costs and improving time service. The moral of that story is look very carefully at the composition of your sales before you jump.

To summarize, the theme of my remarks is to gear your underwriting practices to your marketing strategies and not to your underwriting desires, which is another way of saying, "don't lose the forest for the trees."

MR. JAMES D. BROCK: The topic of my presentation is underwriting for persistency. When I think about underwriting for persistency, I think of some visible actions like the rules some companies used in the last two to four years when they refused to write certain term policies that were obviously being re-entered. That is the kind of visible thing that underwriting for

persistency brings to mind to me. We are not doing anything dramatic like that, but we do have a little project going on that might be of some interest.

Let me start with a description of what we now do in underwriting that you might call underwriting for persistency. Perhaps some of you will share some other steps you have taken. I think some of you may also classify what I call underwriting for persistency as simply good judgment underwriting and I basically agree. Here are some of the things we are doing:

- We will decline applicants with obvious financial difficulties where there is a questionable need for the insurance. We would expect poor persistency and considerable mortality antiselection by those who do persist.

- We look very closely at those who rely on transfer payments, and we will not issue to those whose sole source of support is welfare.

- With a few exceptions, we will not issue to enlisted military personnel in pay grades E1 to E3 who are below age twenty with no dependents. We also limit the amount which we will consider on those enlistments below twenty without dependents but who are E4 or higher.

- We insist on annual premiums for people who we learn are buying just before taking a big trip. Obviously, we are not priced for trip insurance.

In the last year or so, we have been expanding more actively into the brokerage markets. This has been attributable particularly to our capacity, the largest in the industry, and to our very competitive underwriting on some substandard risks. Nonetheless, we are treating, with care, applications suggesting high early lapse rates, such as those for large amounts of term insurance where the coverage has obviously been moving around every year or so. We have not established official guidelines that we will not take certain cases. Nonetheless we do plan to follow our experience closely and try to react quickly with implementing necessary rules if we do identify a problem.

We are also not interested in covering short-term needs in this large-amount brokerage market. For example, we saw an application for a very large amount on a movie producer with the insurance intended to provide coverage while he was making a movie. Since the total need was only for about a year, we were not interested.

The guidelines I have described are not too difficult to arrive at on a general reasoning basis. One of the keys to any kind of underwriting for persistency has to be the credibility of the rules with the agents. Unfortunately, we do not have detailed data to define and sell a lot of rules on underwriting for persistency to the agents. Clients are individuals and it is not easy for a Home Office underwriter to convince an agent that the case is likely to lapse and, therefore, would be a losing proposition. I am not sure we will ever be comfortable with refusing to accept an application because we expect poor persistency except in the kinds of special situations that I have mentioned. One of our agency executives frequently reminds me that persistency is a field job. I think he is more correct than we might wish, but it does mean that we and the agencies must work together to make sure it does happen in the field.

Our new project is a step in that direction, but it is not so much an accept or decline situation. It is really aimed at directing the agent to sales where business is more likely to persist.

The project is based on a persistency rater. It is being tried in our Ordinary Agencies, which include about 4000 agents whose target market is the upper middle and higher income markets.

We call it the confidential persistency rater. It is designed to measure the likelihood of a policy remaining in force for at least two years. It evaluates buyer-related factors and product-related factors based on an analysis of our experience and predicts the expected persistency of the policy.

We believe the rater is a valid measure. We tested it against over 2600 policies issued in late 1982 to determine how their actual persistency related to the persistency rate predicted at issue. Top scoring policies had an expected persistency of 90% -- the actual was 95%. At an expected persistency

level of 70%, the actual was only 60%. The lower the expected persistency, the more actual experience was even worse. We felt the results clearly supported the value of the rater. They suggest a very conservative approach on applications scoring low on expected persistency.

The persistency rater looks at the following kinds of buyer-related factors: age, occupation, marital status, family income, whether the proposed insured is a prior policy owner, and who is the premium payer. We have identified the preferred characteristics. For example, married lives persist better, and people with previous Prudential coverage are more likely to persist. There are different categories of answers and different scores associated with each. There are also policy-related factors in the rater. They include: policy type, the amount of the annualized premium, payment mode, and whether a medical exam is required or not. I am sure you can think of other buyer-related or policy characteristics which you might want to consider or you may already be using.

I should mention our rater was developed from the rater produced by LIMRA. LIMRA's rater has been well tested, but we believe it is necessary and appropriate to modify the rater for the characteristics of your own agency force, your own markets and needs, including recognizing your own pricing assumptions. For example, we also have a District Agencies Field Force of about 19,000 agents. They are in the home service and middle income markets. At this time they are not using a persistency rater. If and when we extend the persistency rater to them, we will clearly need to study their business and adjust the weights and scores to reflect the differences in their markets and operations compared to that for our Ordinary agencies. One difference is that they have a heavier emphasis on monthly business including Debit Ordinary. A rater design which discouraged monthly business would be contrary to their basic operations. We will have to adjust any kind of rater for them to recognize the importance of monthly business and the kind of lapse rates associated with this more home service type of operation.

Here is how we are using the rater. We have made it available directly for the agents to use. We have provided them a guide on how to use it. Since their persistency has an impact on their earnings and awards, such as conference

qualifications, they have a definite incentive to use this kind of tool. It is not required though, except at the discretion of the local agency manager. Hopefully, it does at least have an influence on the agents' general marketing approach, particularly for new agents. While we encourage agents to use the persistency rater, the results are not used by the Home Office.

Now we have gone further to promote the persistency rater in the field. We capture the necessary data through our new business system which is used in underwriting and issuing policies. We have developed a system which automatically calculates and prints out the total score as each application is entered into the system by the new business clerk in the agency. That is, when the clerk keys in the information from the application, an output record is immediately produced for the agency. The persistency rater total score and expected persistence have been added to that record. The Agencies Department has suggested to the agency management that it might want to have the new business clerk automatically notify the manager or general manager on cases which produce an expected persistency less that the specified percentage, such as 60%. I understand some managers refuse to accept business from agents with high lapse rates unless the application produces a minimum score such as 60% or 70%.

We have added two management reports designed to give quick information. There is an agency-level report produced weekly in the agency which provides a computerized summary of persistency rater data for all applications entered into the system the previous week. Detailed records and summaries are available by organization unit from the agent up to the total agency. In addition we have reports available for Home Office agency management in each of our sales regions. These reports are generally produced as quarterly summaries, but detailed data for each agency and even down to the agent level are available, if needed. The idea is to provide these executives appropriate persistency rater data to use as they work with the Agency General Managers who report to them.

These reports produced by the system have only been introduced this year. Since persistency is a significant element in sales management compensation, the reports have been generally well received. I understand our corporate

agency executives have gotten a lot of good feedback, but only time will tell how many people really use the data effectively, particularly in view of all the other demands on agency management. I would expect it to be used selectively by managers whose compensation is being hit hard by poor persistency. More generally, it probably will be used with relatively new agents to make sure they develop on the right track.

The next phase of the system will be the follow-up measure of actual persistency. The system will build a file of the records entered. Each record will remain on the file about two years. Lapse records from the valuation area will be matched with the applications, and the results recorded to compare to the predicted persistency results.

In setting up the follow-up system, you have to go through a number of detailed questions such as how you handle term conversions, lapses with reinstatements, multiple reinstatements, and policy changes with reductions in amounts, etc. We are setting up the systems, but it will be a couple of years before we start recording actual versus expected results. That will be the true test of the whole effort. There will undoubtedly be a whole lot of "yes, buts" such as "I wasn't the manager then", or "It was in the insured's best interest to rewrite that term policy instead of reinstating", and other similar comments. However, if the actual results compared with the predicted results generally say "I told you so" on cases in their own agency, the rater will really make a lot of believers, and that should lead to better and more profitable sales. Already we have had an indication of this. We have had some persistency seminars in certain of our sales regions and have selected some lapsed policies for the agents present in the seminar. Then we applied the rater to the actual cases and showed them the validity of the rater just by the fact that these cases would not have passed the rater standards in most cases.

While our District Agencies do not use a persistency rater, I should mention briefly a program they do have. They call it the business practices program. It is aimed at identifying agents who are relying on their inforce business to generate new business premium through policy loans, automatic premium loans, and cash surrenders. These kinds of sales are frequently structured to get enough money out of the old policy to ensure the new policy will last for up to

two years. By that time, the old and/or the new policy will probably terminate. This program is directed from a high level in the Agency Department at the Home Office. Statistics are produced monthly. They show the offices and specific agents whose business practices are out of line. Executive attention starts at the corporate level and follows through down to the management of the local office. We believe this program has been very effective and has helped discourage some poor persistency new business where no new premium flow is likely on the new policy after funds from the old policy ran out. The program has also been considered a great success as part of our efforts to avoid increases in lapses of old policies with the introduction of our Universal Life products.

Now let me change topics a little bit. Howell eluded to the trend to emphasize investments instead of life insurance in sales, particularly at the higher issue ages. The emphasis on investments is not surprising in the interest-sensitive products. We see it particularly with our very successful Variable Universal Life Product, but it is creating some special challenges for us in our underwriting. We believe we still must underwrite for needs to achieve successful financial results.

On the other hand, it is our impression, and certainly the impression of some of our agents: that there have been actual limitations in routine requirements and special tests ordered because of the investment nature of the policies. We hear that large drop-ins often influence thinking on substandard rating actions. Agents seem to be more comfortable with placing rated cases on interest-sensitive products. That is due in part because of the inherent flexibility of the products. That likely translates into higher rates of placing substandard ratings. Presumably a major factor in all of this for the underwriter is the assumption that antiselection is minimized because the death benefit was essentially only an incidental part of the sale.

Nonetheless, it is apparent to us that we can expect a significant degree of antiselection by the insured in a group of sales at high ages where there is little or no need for insurance. We see this kind of antiselection through our experience studies and early claims. We even see it during underwriting. For example, there was a single pay life case on a person with a recent history of

quadruple-coronary bypass. In another case, the examiner reported the proposed insured was having difficulty breathing while sitting at rest in a chair. These higher age people, of course, are the ones who often have the big drop-in money available. No doubt the investment opportunities or products are attractive and competitive. The opportunity to improve upon the investment return through the life insurance, however, seems to make the deal even more sporting for some people.

I might add we occasionally see some problems at juvenile ages where inappropriate amounts are requested because of the investment features. We are leary of cases which appear to violate what we consider to be good underwriting principles. A simple example would be selecting only one of several children for a large amount of coverage for no apparent good reason.

We have implemented some underwriting changes at higher ages recently because of our experience. We require medical examinations and will no longer accept paramedicals at these ages. We order APSs on all the cases. I must add that in working with our Agency Departments on this problem we did liberalize slightly the amount of "burial insurance" we allow at these ages -- that is, the amount we allow without demonstration of the need for the insurance but we do count any existing coverage against that limit. The bottom line is the real investment-oriented products are not available unless there is a clear need for the insurance.

The results of our underwriting changes are what you would expect. Our life rejection rates are up at these ages, and there are many in the field who disagree with us on specific cases. However, we have emphasized the need to improve our experience to have competitively-priced products. There are enough actual claim stories to get peoples' attention. Our Agency Executives are generally supportive of our efforts.

In summary, we know there is a lot of truth to the statement that the investment features rather than the life insurance are the basis of the sale in many instances. We are told, and we believe, some companies are totally disregarding the need for coverage at both the juvenile and higher ages on such sales.

We think companies can get away with this kind of underwriting for awhile. We do not think it will work in the long run.

MR. WOODMAN: My comments are directed toward the underwriting of larger amount cases where we clearly need some fairly substantial underwriting information to guard against significant antiselection.

In the last decade, we have seen very significant trends towards reduced use of certain underwriting requirements. Medical examinations and inspection reports are now required only for quite sizable amounts. EKG and chest X-ray limits have been greatly increased.

These changes have been partly caused by a decrease in value of these underwriting requirements. Medical examinations are often rather superficial and many of the impairments for which a physical examination is most useful -- for example, elevated blood pressure and heart murmur -- are found with less frequency. Because of privacy concerns, inspection reports are less revealing, particularly with respect to sensitive areas such as alcohol and drug use. Electrocardiograms obtained routinely for age and amount have a high frequency of questionable results. Chest X-rays are frowned upon in some circles because of exposure to radiation.

For these reasons, underwriters have looked for new, less expensive, more productive ways of obtaining information to identify adverse risks. Companies are now extensively using paramedical examinations and in-house telephone inspection interviews.

Among the more recent developments are the several new tests that are now being performed on blood and urine samples. These tests are quite valuable because they can be administered inexpensively and because they are reliable in terms of sensitivity and specificity.

A blood sample is not obtained by a fingertip pin prick as is done to obtain a blood count. It is a vein puncture, and some companies have been reluctant to have this procedure performed. However, now one rarely sees an Attending Physician's Report of an annual examination that does not contain a blood

screen. There is currently very little resistance to obtaining a blood test in connection with a life insurance application for a sizable amount.

A paramedical technician or doctor will draw the blood which is then sent to a laboratory -- most frequently one that does blood screening solely for life and health insurance underwriting purposes. These laboratories have testing that is directed toward obtaining results that are most useful for underwriting. The tests are performed within twenty-four hours of receiving the blood sample, and the results are telecommunicated immediately to the insurance company underwriter. The results are in a form that does not require skilled technicians or doctors for interpretation as do EKGs and X-rays.

The key blood tests for the underwriter are glucose and cholesterol, newer more sophisticated tests that also suggest a predisposition towards diabetes or heart disease (hemoglobin and high density lipoprotein, called HDL), a very valuable liver function test (GGT), and the well publicized tests pertaining to AIDS. All of these tests can be made from a single blood sample.

Many other tests are also routinely made as part of this screening. Some of these additional tests are of a diagnostic rather than a predictive nature. By that, I mean that they are generally normal, but when they are elevated, there is usually some immediate cause which must be identified before an application can be approved. Others, such as most of the ones I mentioned earlier, are essentially predictive because they do not show a disease process of immediate concern but suggest a long-term adverse effect on mortality.

There are also a number of urine tests which can be obtained at reasonable costs. These tests are quite accurate and reliable. The urine dip stick completed as part of every medical examination has also been an extremely important underwriting tool. The expense is minimal, and the test readily identifies sugar and albumin. Recently, laboratory tests that are relatively inexpensive and accurate have been developed with tests for nicotine and drugs, as well as for antihypertensive and diabetic medications. In addition, the traditional laboratory tests for microscopic hematuria, pyuria and casts, and tests for quantities of sugar and albumin are completed.

With the increasing relative importance of blood samples and urine specimens, we are seeing a decreasing use of electrocardiograms and chest X-rays. Many of the EKG deviations that occur in a healthy individual are not significant to mortality. Moreover, EKG requires interpretation by a doctor or technician which is an added expense and possible cause of delay. The chest X-ray can indicate the presence of a lung nodule, but its use as an underwriting requirement in an apparently healthy individual is being increasingly questioned because of the exposure to radiation, as I mentioned earlier.

The utility of the new blood and urine tests merits some discussion. The GGT is of great underwriting value because an elevation is most likely to mean excessive use of alcohol. In some instances, the elevation may be due to other causes, but the significance of these causes is equal to or greater than an alcohol problem so that underwriting action based solely on GGT results is still warranted. The GGT is of particular value because it is not sensitive to an isolated incident of overindulgence. It takes a long period of excessive drinking to register abnormal values. Also, one cannot avoid abnormal values by abstaining for a few days. It takes several weeks of abstaining before GGT values return to normal. To sum up, GGT answers the two underwriting problems associated with tests -- it is positive only where there is a definite problem and one cannot prepare for it. The GGT fills a void left by the reduced amount of data about excessive drinking indicated in the inspection report.

We have all heard a lot recently about tests for AIDS antibodies. All companies in the insurance industry use labs that follow a procedure that virtually insures that a positive result is a true positive, that is, a true indication of the existence of AIDS antibodies. First the ELISA test is performed. If this is positive, and a repeat ELISA test is also positive, the Western blot test is performed. The Western blot is a sophisticated, relatively expensive test which has a very high ratio of true positives.

This combination of tests meets the true criteria of useful testing. The ELISA test is highly sensitive; that is, it identifies virtually everyone who has AIDS antibodies. The Western blot is highly specific; that is, it excludes virtually everyone who does not have AIDS antibodies. It is many times more likely in this testing procedure that a person with antibodies will be missed

than a person without antibodies will be falsely identified as having antibodies. This is quite a crucial issue today as you can well imagine.

This leads to a discussion of the Bayesian distribution, which is a basic concept in all types of testing. If the population being tested has characteristics which make them more likely to have the condition for which they are being tested, then a positive result is likely to be a true positive. On the other hand, if a random sample of the population is tested which includes primarily people who are not likely to have the condition, such as when tests are required for insurance based on age and amount, then a positive result is more likely to be a false positive.

For example, a positive stress test in a fifty-five year old male cigarette smoker is highly likely to be a valid result, whereas the positive result in a twenty-five year old female nonsmoker is more likely to be a false positive. Similarly, a positive series of AIDS antibodies tests on the thirty-five year old single male residing in Manhattan is almost certain to be a true positive, whereas the same result on a fifty-five year old married male residing in Kansas would be viewed with less certainty, in spite of the extremely high accuracy of the test.

It is for these reasons that physicians in private practice are selectively deciding what tests to employ on a routine physical examination. If the chance of a condition being present is remote, the doctor may not obtain the test, not only because of the expense, but because a positive result would cause great concern about the possibility of having the condition when, in fact, it may not exist.

The relatively new urine tests that are being utilized by life insurance underwriters are also important underwriting developments. It is only within the last few years that a test for nicotine has been developed that is sufficiently accurate and inexpensive to be suitable as an underwriting requirement. This test identifies tobacco users, some of whom may not have admitted use on the application. Although such use could be other than cigarette smoking, my company refuses the nonsmoker discount solely on the basis of the test result, unless we are convinced that the source of nicotine in the urine was from other

than cigarette smoking. The test quantifies the amount of nicotine and thus casual exposure can be dismissed. The one drawback is that it is relatively easy for a proposed insured to avoid a positive test result by refraining from smoking for forty-eight hours.

Another useful test, less frequently used and more expensive, is the urine drug screen. A screening solely for cocaine can be obtained at less cost than a complete drug screen. Where we have used the drug screen, virtually every test that has been positive has been for cocaine. It indicates the very widespread use of cocaine, not only among the persons with a lifestyle where you would expect to have drug usage, but also among persons with a lifestyle where you would not expect to have drug usage. The drug screen has a disadvantage similar to the test for nicotine in that a person can prepare for the test by refraining from the use of drugs for 72 hours. It also has a small percentage of false positives, which can cause problems. It is obviously of primary value with risks who suggest a higher probability of drug use such as entertainers and athletes. Otherwise, a positive test result maybe suspect.

Although not of an actuarial nature, this discussion should not end without commenting upon the important concerns of confidentiality and disclosure. There has been considerable concern expressed by the gay community about the adverse effects, particularly on employment, if the confidentiality of information about a positive test AIDS result is not maintained. This can also be a problem with tests that are positive for alcohol and drugs. Companies have taken special steps to insure the confidentiality of these results. At New York Life, we treat every case that is declined because of an examination or test finding in a highly confidential manner regardless of whether the finding is sensitive, such as AIDS antibodies or alcohol, or whether it is not particularly sensitive, such as an abnormal electrocardiogram. In this way, the agent is unable to directly infer that a case has been declined for a sensitive reason.

In all of these cases, we give the reason for declination to the agent as "current medical findings." As I mentioned earlier, this includes the non-sensitive as well as the sensitive cases. We write directly to the proposed insured giving the specific reasons for our action. We write to him or her

rather than to the personal physician designated in the application because we feel that the proposed insured may not want this information made known to that doctor and would prefer to seek medical advice from a doctor in another community. We also feel that we should write immediately rather than delay a case while we await the doctor to whom the proposed insured wants to write. We feel that it is important to get this information to him or her very quickly.

I believe that we will see a trend of increasing use of blood and urine specimens in larger-amount life insurance underwriting. They can be obtained at a reasonable price and produce mortality savings that can greatly exceed their costs. They can be analyzed quickly without causing delay in the underwriting process. No Home Office staff is required for interpretation, as is the case for EKG and X-rays. Finally, the science of testing is expanding rapidly so that I believe, in the future, we will be obtaining significant additional information from the analysis of blood and urine.

MS. BARBARA J. LAUTZENHEISER: You have been talking about the liberalization of your agent amount limits for underwriting criteria. Have any of those been modified or is there any concern about their sizes now that the AIDS issue is a fact of major concern to many companies? Also, what are others doing as far as the AIDS testing is concerned?

MR. JOHNSON: Are we concerned? Yes. I look at our experience to date versus some of our sales projections of a year ago, and am thankful that we are not matching those projections. Metropolitan, with a career sales force working primarily the middle-income, lower-middle-income family market, is protected from the experience that has been reported by some of the other companies. When we look at the circle of our market and the circle of the at-risk group, there is a very small intersection. If we had taken on a whole load of thirty-five year old males with One Year Term Insurance for $100,000, we would not have known they were going to start to drop until another several years had past. So, I am quite concerned about it. As far as testing goes, in view of our experience, and in view of the emotional and political situation, we have adapted a wait-and-see attitude, but we are prepared to test on the appropriate case.

MR. MARTYN: We are one of the increasing number of companies that do routine testing for anybody where permitted, but like most companies, we are doing it at the wrong end of the scale. We start at one million dollars or even two million dollars in the younger ages, and that is not where the problem is, so we are considering the questions of how we can reduce those limits. Can we reduce non-medical limits or inspection limits and still maintain the support of our field force? That is a tough balancing act. The field force has been used to years and years of liberalizing limits on every scale. We cannot, as an industry, demonstrate that we have been hurt yet by AIDS. That is going to be a very tough sale to make.

MR. ROBERT B. WILLETT: We have a lot of complaints from our agents on financial underwriting. We are having a tough time demonstrating to them that we have been hurt by poor financial underwriting.

MR. MARTYN: I do not think there is any question that the industry in the aggregate has been hurt by poor financial underwriting. It is a tough one to answer, but there were companies out there during the late 1970s that appeared to be ignoring what were even reasonable financial guidelines, and the reinsurer was the one who first caught it in the neck. There were obviously plenty of good companies who were not relaxing or only slightly relaxing their traditional guidelines however.

MR. JOHNSON: I think our experience was the same as Howell's. We suffered the slings and arrows of our sales force telling us we that we are the only company in the industry that will not take this particular case. We had enough experience where our underwriters failed to financially underwrite a case, and the case came home to roost as a death claim pretty quickly. I have not received a complaint on financial underwriting in the last three or four years. Before that it was weekly, including those who felt that if the person had the first premium, why worry.

MR. WOODMAN: I am a great believer in the safety-in-numbers theory in financial underwriting. Years ago, when applications on young children or older people were infrequent, we used to be very careful about underwriting policies over nominal amounts. Today, where there are good reasons for

insurance even though they are not entirely economic, I think we have a good deal of safety. It does not eliminate the problem completely.

Another example would be the employee buyout of an employer. When that first surfaced, underwriters were very concerned because it is simply a windfall. Even in a straight partnership buyout situation, it is a windfall if one of the partners dies. The economic loss can be quite minimal, but it is such a convenient method of carrying on the business without discontinuity that it has become accepted. There is safety in numbers, but it does not eliminate the concern completely.

MR. JOHN M. BRAGG: Accurate pricing assumptions are more critical than ever-before. More accurate coordination is needed than ever before between pricing and underwriting. These remarks that I am going to make have to do with the nonsmoking/smoking subject. I wanted to fill you in on a project that we have going on in our consulting firm. It is called the 1986 Nonsmoker/Smoker Main Project. The objective of it is to produce fifteen-year select and ultimate mortality tables in four ways -- male smoker, male nonsmoker, female smoker, female nonsmoker -- and to try to find out where contamination is occurring, the extent of it, the defenses, etc. We have received mortality data from fifteen companies, including major companies, totaling 4.4 million policy years exposed in the period 1980 through 1984. Twenty-one companies supplied questionnaires that have to do with underwriting policy. Overall, smoking males' mortality is more than double the nonsmoking males. The smoking females are slightly less than double the nonsmoking females. Females are far lower than the males.

MS. LAUTZENHEISER: Even the female smokers are less than the male nonsmokers?

MR. BRAGG: They are in the same ball park, I think. The male nonsmokers and the female smokers are comparable. It differs tremendously by age. On the matter of this contamination, it is the older-age nonsmoker males where most of the misrepresentation is going on. I wonder if the panel would say something more about the question of how you detect the misrepresentation from an under-writing standpoint. There has been a lot of talk about it, but what is the

best system? Is it the telephone inquiries? Is it the nicotine test? What works? Do you have to have better questions on the application?

MR. MARTYN: I think all of the above works. You cannot zero out one test and say that is the solution, that is going to cure the problem. You have to attack it on all fronts. You need to get nicotine testing in your urinalysis at some level. You may pick different levels depending on whether the applicant is an alleged smoker or nonsmoker. You need to get inspections at some level. The telephone history, if done properly, is a good source. It can be done not only routinely, as an inspection is, but used as an audit tool where you have agents or agencies whose record of history taking is suspect. The APS is a good source. One of the things that I see coming is that we will get to a position where we do not ask about cigarette smoking -- we will ask about tobacco use, and, therefore, treat tobacco use as an impairment.

MR. BRAGG: How do you feel about prorating versus rescission?

MR. MARTYN: A misrepresentation is a misrepresentation -- smoking is a legitimate insurability question which can be misrepresented. We state that we intend to rescind or to deny coverage. We have not been put to the acid test yet. So, whether we would actually do that in a given situation, I cannot say. We would not prorate the amount of insurance by age adjustment which I understand some companies publish that they will do. I think that is a great mistake.

MR. WOODMAN: Is that statement in your application or is that just a statement of your policy?

MR. MARTYN: The latter.

MR. WOODMAN: We have filed an application with a statement in it to point out to the applicant clearly that we consider this question a cause for rescission if there is a misstatement. Without that, we have been concerned that the small size of the premium differential, particularly in permanent insurance, does not give us a very strong case for rescission, particularly if we have not emphasized the fact about our concern for the correct answer to

that question. So, we are trying to enforce our position, but I do not think that the adjustment of the premium is any penalty at all. It is a very minor penalty and only if the person gets caught. It does not seem to me that that would be a significant deterrent.

Allan, are you doing something to track agents who have clients that are nonsmokers in high proportions?

MR. JOHNSON: Yes. We compare what we get to what we expect, and we have not had too many fights over it. There are people who work special markets, and we have other factors that cause lower than expected number of smokers, but we expect that those sales representatives will be giving us the number of medical histories, the number of overweights, and other things that we expect. In these situations, where we find sales representatives with a significant number of cases who somehow cannot develop what we expect, we supplement their efforts with a paramedical evaluation and a specimen which is tested for nicotine. We just started doing this, and our first crack at it produced 11.5% smokers among those who professed to be nonsmokers.

MR. BROCK: We are doing a similar thing to what Harry has described as far as putting our policy regarding possible rescission into the application. Some recent statistics that our people have put together confirm your findings about the high ages being the biggest troublesome area. We also seem to have a higher apparent problem on term insurance than on permanent insurance. The difference between smoker and nonsmoker premium is relatively greater on term insurance.

MR. BRAGG: Out of the same material, we can get smoking percentages. There is a smaller percentage of males who claim to smoke than we know is true of the general population, but not of females.

MR. WOODMAN: Jim, your persistency rater has shown that it is pretty accurate in identifying what policies are going to persist. Do you have any indication that there is any significant mortality differential between high lapse and low lapse business?

MR. BROCK: We have not looked at that. The data base that we are now building through collective information on the applications will be able to do that in the future. That has not been our primary concern. Obviously, poor persistency and the relative expenses have been the bigger concern.

MR. JAMES W. PILGRIM: We are having quite a discussion in our operation about single premium drop-in situations, particularly among the older-age and the younger-age insureds. Are these truly better risks because they are buying the coverage as an investment as opposed to insurance? Therefore, can you afford to be more liberal in your underwriting, including financial underwriting? My position is that if it was really an investment, and that was the reason they were buying the coverage, why did they not buy an annuity or something else? I guess my feeling is colored by the fact that about fifteen years ago, with a company that I used to work for, we had a program in the Group Department where if somebody put $15,000 in a savings account in a bank in New York, we would provide him with an equal amount of life insurance coverage. What happened was we had a bunch of families with children who had terminal illnesses. They would go to another bank to borrow the $15,000 to get the $15,000 of coverage. In three years, we experienced 400% of group mortality. We get pressure because people say they are not buying it for the life insurance aspects, but just to qualify for TEFRA. I do not believe it. I think the need has to be there. I think we have to underwrite that like any other risk. However, I hear you saying there is safety in numbers when letting them buy these big amounts.

MR. WOODMAN: I am not saying we should not do any underwriting by any means, but I think we can afford to be more liberal in our underwriting. You do have to ask whether or not that person has cancer or has had quadruple by-pass. In other words, you have to ask enough to eliminate the uninsurables and the highly substandards. If they die soon, then you may have a basis for rescission. I do not think that you have to go through the full battery of tests that you normally go through at those older ages because I think the main motivation, once you have eliminated the opportunity to really cheat, is the financial one. Again, I cannot disagree with Jim's position that you cannot ignore financial underwriting. In general, somebody who has a big chunk of money to put into a Single Premium Whole Life policy probably has some kind of

a problem that would merit some amount of insurance proportionate to that chunk of money.

MR. BROCK: I am not trying to say that we are absolutely rigid. We try to be reasonable about it. We have to look at the issues because we have seen enough cases that are made for pure investment. You have got to take a fairly close look at it just to be sure that it really does make sense. Maybe we are just talking about differences in degrees. One of our problems has been getting some of our underwriters to pay attention to the financial underwriting aspects rather than approving just because this insured had this big CD maturing. You have got to get them to pay attention to the question before you go and put the approval stamp on it.

MR. HENRY B. RAMSEY III: What is the first age that you allow a nonsmoker discount and charge a lower rate? Do you only allow it after age twenty-two, as we do, and, if so, what do you do for a person who bought insurance at age twenty, and then at age twenty-two wants to be reclassified as a nonsmoker?

MR. JOHNSON: We start at eighteen, and we have, since around 1907, had a preferred class beginning at some age other than zero. If the insured wants it, what he/she needs is replacement. We will replace it subject to underwriting and starting over again with the cash values, etc. If they want an original date change, we cannot do it. We do not have the classification to maintain the original date and the original age. It is not really a problem.

MR. WOODMAN: Another possibility in handling that is simply to have your aggregate rates in the teens grade right into your nonsmoker rates in the early twenties. That results in some adjustment of the two to make them grade in evenly, but a gross adjustment is not required because the premiums are relatively small at those ages.

MR. JOHN B. DINIUS: As long as we are talking about nonsmokers, I might add that Aetna has considered the possibility of handling the youth nonsmoker problem by saying that anyone who buys insurance under fifteen is a nonsmoker and will be treated as such when he reaches adulthood. Starting at fifteen, you do have the separation.

My question is for Allan Johnson. You mentioned in your remarks that you have done some studies on different agents. How often they answer certain questions "yes" or whether, on the other hand, they indicate that all their clients happen to be nonsmoking, slim, nonhypertensives. You indicated that those who do answer "yes" frequently enough to indicate they are being truthful are rewarded with higher non-medical limits. First, why did you choose to have only a carrot and not a stick and lower the non-medical limits on the others? Can you afford that? Secondly, did you actually do mortality studies on an agent-by-agent basis? It seems as though it would be very difficult to have enough experience to get any credible figures on the individual-agent basis.

MR. JOHNSON: The fact that I did not say we had a stick does not mean that we did not have a stick. We have a small but yet significant number of agents who no longer write non-medical business. On the topic of credible mortality figures, we could only do it by groups of our agents. No one agent or no handful of agents in Metropolitan has a big enough book of business to produce credible results. And that is the frequent appeal from agents -- why don't you look at my claims. Of course, we do not hear from those agents who have lousy claim experience. It is difficult enough for us to get significant mortality results by regions on a year-to-year basis. It is just impossible to get them on a sales-representative basis or sales-outlet basis.

MR. WOODMAN: Allan, you indicated that you had a problem in communicating a change in underwriting philosophy when you started doing your "Simplematic" underwriting of salary allotment business. Apparently, underwriters who were used to applying regular underwriting rules and fairly strict underwriting suddenly virtually stopped underwriting altogether because of their perception of what you wanted. How did you resolve that problem?

MR. JOHNSON: We had a few cases, and we used those to illustrate what can happen if you do not do anything. We had not explained it thoroughly. Our objective is to issue as much as we can at the lowest possible cost. Somehow that got twisted that we wanted to issue everything. It was clarified fairly quickly. We always look for opportunities. It was an opportunity for us to learn how important simple and concise explanations and directions are to people. It is hard for them to guess what you want unless you tell them.

MR. THOMAS P. MCARDLE: Have you added an AIDS question to your application? If so, what states are allowing you to ask that question?

MR. WOODMAN: The primary problem seems to be with a question regarding AIDS testing rather than the question regarding AIDS itself. I do not have the figures here, but we have filed an application with both of these questions and have received approvals in approximately thirty states, disapprovals in eight or ten, and have some open questions in another eight or ten. It is something of that order. The whole process is really up in the air now. I think the most critical question for many companies, at least those of us who operate in New York, is exactly what New York is going to do with respect to allowing application questions about AIDS testing and with respect to allowing testing for AIDS antibodies. We are treading water at the moment awaiting resolution to some of these questions to decide which way to proceed.

MS. LAUTZENHEISER: I believe there are forty-two states that do allow the question. It is about eight that are doing some questioning. New Jersey has just come out with regulations. Maine has just come out with regulations. Some of those are clarifying. Also, the NAIC Advisory Task Force on AIDS is looking at questions on applications, so I think it will become clearer.