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THE FUTURE OF UNDERWRITING AND RISK CLASSIFICATION

Moderator: RICHARD V. MINCK
Panelists: JAMES W. DEDERER*
ROBERT K. GLEESON, M.D.**
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JOHN T. SNORE***
Recorder: DANIEL F. CASE

- Impact of the AIDS epidemic
- Legal challenges to risk classification practices (including unisex, blindness and AIDS bills or regulations)
- Impact on practices resulting from these challenges and from trends in areas such as preferred risks and guaranteed issues
- Possible future developments in underwriting and risk classification and how they may impact product design and marketing

MR. RICHARD V. MINCK: We have a very distinguished group of panelists. Our recorder is Dan Case, Actuary with the American Council of Life Insurance, and someone who has worked very heavily in the area of risk classification for many years. Dr. Robert K. Gleeson is Associate Medical Director of Northwestern

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Mutual Life and a Fellow of the American College of Physicians and a member of the Boards of Insurance Medicine. He has been with Northwestern Mutual for half a dozen years, and has been very active in some of the questions that are currently facing the underwriting profession. John Snore is Vice President, Underwriting, of the Prudential Insurance Company of America. John has been with the Prudential for about 30 years and is a past President of the Home Office Life Underwriters Association. He is on the board of the Medical Information Bureau. He has been involved in the struggle to maintain risk classification procedures for at least the last 15 years. John has been good enough to chair our various committees on the subject.

We also have Barbara Lautzenheiser, the Principal of Lautzenheiser and Associates, of Hartford, Connecticut. She is the past president of the Society of Actuaries, had been the Senior Vice President of Phoenix Mutual, and the President of the Signature Group of insurers before going to her own firm. She is a native of Nebraska. The heart of the panel is from the heart of the country.

Next is Jim Dederer, Senior Vice President and General Counsel of Transamerica Occidental. Jim has been with Transamerica about 15 years. He is in charge of their Government Relations Department, and he has done a lot of work in the tax area as well.

The panel is looking at the question of underwriting and risk classification. This is in the context of an area which has had currents swirling in several directions over the past decade. On the one hand inflation, improving mortality, and expense considerations have led to less underwriting for a lot of policies, a lot a nonmedical business being issued, and various forms of underwriting being used that were perhaps less strenuous. On the other hand, we have started making classifications for smoker and nonsmoker and other categories that are a lot finer than we have ever done before.

We're caught in the midst of two or three broad social movements and one catastrophe that push us in various directions. The broad social movements have been the pushes towards civil rights and equality. While what we have been doing produces far more equitable results, that is a very hard concept to

sell in the context of lawyers and courts that are accustomed to dealing in terms of equality, with anything else being suspect. Of course, the AIDS epidemic has been a well-publicized catastrophe. The end may be a long way from sight.

DR. ROBERT K. GLEESON: Some time in the 1970s a virus changed somewhere in central Africa and began to infect humans. This mutation marked the beginning of a brand new disease called AIDS. This HTLV-III or HIV virus belongs to the rare group of viruses called retroviruses, and they are nothing like the viruses that cause mumps or the common cold. Retroviruses actually become a part of the genetic code of an infected person. They become part of an infected person's DNA. This means that when a person is infected, they are infected and infectious for life and will develop AIDS at some fixed rate. When a person is infected, they will be a true confirmed test positive by the testing procedure ELISA, ELISA, Western blot.

It is clear that in America in the 1970s we had zero AIDS cases. Today we have had almost 26,000 reported AIDS cases, more than half of whom have died; and we are in the infancy of this disease. It is believed that in America today we have 1 to 2 million HIV infected people. Think about that: 1 or 2 million infected people who by current estimates will develop a fatal disease at the rate of 2 to 6% per year. And some of you tell me that you don't have a problem. Furthermore, the number of infected people in America is continuing to increase because we have not had a major national educational program.

Let's talk for a moment about education. To date, the major risk groups for this disease are gay and bisexual males, IV drug abusers, transfusion recipients or hemophiliacs, and children born to infected mothers. The number of heterosexual cases in America has been small, but is increasing and will continue to increase.

The HIV virus is spread by sexual contact or blood contamination. It is not spread by working near somebody. It is not spread by eating in a restaurant with a gay person. It is not spread by sneezing. It is not spread in classrooms. It is not spread on toilet seats. Spread of the infection is prevented by education, by recognizing that any sexually active person in America can get

this virus, by the use of condoms in all non-monogamous sexual relationships, and by not sharing needles.

Some people believe that the current drug treatments such as AZT will provide relief from the epidemic. While I welcome the introduction of AZT, it is only an initial step in the process of finding something to control this terrible disease. We are years away from an effective treatment, and we are still further away than that from an effective vaccine. Also, the vaccine will be given to non-infected people, as anybody who is infected will be untouched by a vaccine. I do not anticipate effective medical therapy for at least 7 to 10 years, and I know of no one who is predicting successful medical therapy within that period of time.

The spectrum of the disease follows being infected to going to progressive or persistent generalized lymphadenopathy to going to AIDS-related complex to going to the disease AIDS itself. This has prompted our company, Northwestern Mutual Life, to proceed with HIV antibody testing by the very reliable testing protocol of ELISA, ELISA, Western blot on a nondiscriminatory basis and with detailed attention to confidentiality.

In July 1986 the United States Public Health Service estimated that by the end of 1991 there will be 270,000 (cumulative) cases of AIDS in America and 159,000 deaths, with 54,000 deaths and 74,000 cases occurring in that year alone. Who wants to tell me they're not concerned?

The laws of large numbers apply both for us and against us -- you cannot escape these additional and unpriced deaths. We will see increased losses in individual and group life, health and disability insurance.

To date NML has paid 71 AIDS death claims that we know of, for a total of $5.4 million. By the way, you do not know the cause of death from New York City, which has a third of the AIDS cases, because they don't put a cause of death on a death certificate, and by national figures the underreporting on death certificates is somewhere between 10 and 20%. So that's an underestimate, or an undercount, of our actual AIDS losses.

NML's claims have occurred at the rates of 2 in 1982, 1 in 1983, 8 in 1984, 32 in 1985 and 28 through August 1986. Our same projections, which indicate that our company will pay $100 million in additional death claims for AIDS by the end of 1990, indicate that we should have had 33 claims last year and 48 this year. Last year we had 32; we were off by 1. This year if you carry out the numbers we are going to have 51. You can see we are right on target. In 1985 we paid less than 0.7% of our total death claims for AIDS. Our average AIDS death claim is $70,000 compared to our average death claim of $19,000. It is also interesting to note that 13 of our 71 AIDS deaths have occurred during the contestable period -- the first 2 policy years -- but we have only been able to contest 3 deaths; and we are being sued on two of those.

These numbers and this epidemic are inescapable, and they imply significant losses for all insurers. But more than that, they imply significant challenges for all society; and I hope and pray that we as individuals can continue to meet this epidemic with knowledge and understanding.

MR. MINCK: The next speaker, Jim Dederer, is going to talk a little about the lawyer's view of what is going on.

MR. JAMES W. DEDERER: Let me talk for a few minutes about the law, and the politics of AIDS as it exists right now in the context of our risk classification system. If you've been following what's been happening over the past few decades, you know that the challenges and threats to our risk classification system are attributable to probably two factors:

1. The maturing of the civil rights movement from a focus on basic freedoms to a focus on economic issues as they affect distinct singular groups in our society (e.g., blind people).

2. The tendency in our judicial system to construct a "safety net" for those members (groups) of our society who don't otherwise prosper.

Rather than dote too heavily on those concepts, let's talk about how AIDS fits into the overall picture. I think the AIDS "problem" on the legal, legislative, and regulatory front is attributable to two phenomena. Phenomenon #1 is

the extraordinary degree of ignorance and misconception that exists about insurance and how it works.

At the D.C. hearing on AIDS this past winter, there were a number of comments that reflected the public ignorance about insurance. I'm going to give you just four examples.

1. The 80% of seropositive people who won't develop AIDS should be allowed to buy insurance. A test that prevents access to insurance to the 80% who won't get AIDS is unfair.

2. If half a million people will die of cancer in a year while only 16,000 die of AIDS, why are we not more concerned about cancer?

3. Insurers should bear the costs of life-threatening diseases, not the public.

4. Insurers should underwrite based only on what a person can control (e.g., smoking).

In short, to the public the concept of risk classification is elusive at best. Understanding why risk classification is so essential to our business is even more difficult for them. Risk classification is easily subordinated in the minds of many people when it is juxtaposed against perceived civil or social rights, such as you see presented in the unisex, blindness and AIDS context.

Phenomenon #2 is that AIDS is particularly controversial because our risk classification system is pitted against one segment of society, the gay community, which is quite unique in its characteristics.

There are tens of millions of gay and bisexual Americans. They are economically and politically powerful. They generally are not physically identifiable. Their status is not universally empathized with and, most significantly, many of them are not known to their friends, family, and employers as members of this group; and they want to keep it that way.

For these people issues of confidentiality, employment security, and fears of public censure readily transcend insurer protestations about risk classification. It is a very scary thing for the fully closeted gay person to envision his name being on some computer register for having tested positive at some time. It is these considerations that are fueling the legal and regulatory challenges.

From our perspective as an industry, AIDS couldn't have targeted a worse group. In essence, factors and considerations totally irrelevant to insurance and its operation are threatening our fundamental principles. If AIDS afflicted only hemophiliacs, or only drug addicts, or only left-handed bus drivers, we would not have our current problems with risk classification with regard to AIDS.

The legislation that is out there in enacted or proposed form to limit underwriting latitude with regard to AIDS is a direct outgrowth of political power wielded by the AIDS constituency. Specific restrictive legislation exists in California, the District of Columbia, and Wisconsin.

In 1985 California enacted a prohibition on the use of AIDS antibody tests for purposes of determining insurability. You can make a technical, formalistic legal argument that this doesn't preclude the use of antibody tests for screening purposes in underwriting as long as something other than these tests is used for the final determination of insurability. I'm not aware of any insurers willing to bet their future on this interpretation, however.

It's accurate to say that this California restriction on antibody testing was ushered in under cover of darkness. It was added at the eleventh hour by the AIDS community to an otherwise innocuous employment bill. It caught the entire insurance community unprepared and was enacted before an effective response could be mounted.

The California legislature has a hearing scheduled for October 21, 1986, to address a diversity of issues related to AIDS. At that time we will re-emphasize the insurance concerns about underwriting and testing and we hope to begin a dialogue aimed at correcting the law.

In Wisconsin, a law was enacted in 1985 which precluded use of antibody tests until the state epidemiologist should find that such tests were "medically significant and reliable" and the insurance commissioner should approve such tests for their use in underwriting. The state epidemiologist has recently so approved antibody tests. It is now up to the insurance commissioner to act and approve their use in underwriting. He has not yet done so. The industry is very hopeful that that will be done so that by January, 1987, we will be able to use the tests in Wisconsin, but that is by no means a certainty.

In the District of Columbia, what is by far the most restrictive measure was enacted in June, 1986. It effectively proscribes the use of any blood tests in the AIDS underwriting process as well as reference to any personal characteristics. Gratuitously, the act does not prohibit underwriting or rating of people actually diagnosed with AIDS.

A court challenge to the D.C. AIDS ordinance -- a very well orchestrated action undertaken jointly by the American Council of Life Insurance (ACLI) and Health Insurance Association of America (HIAA) -- was recently rejected in federal district court. A reading of the opinion indicates that notwithstanding serious misgivings about the D.C. ordinance ("this court questions the wisdom of the D.C. law, as drafted. . .") the judge accorded great deference to the District's independent prerogative to legislate. Interestingly, the court suggested that it might have come down differently had the D.C. City Council had access to the Wisconsin epidemiologist's report when it acted.

One unresolved issue in D.C. is the geographical reach of the ordinance. According to the District Court, the ordinance applies to insurers doing business in the District. (Narrow construction: Does this mean physically signing applications and taking premiums in the District? Or broad construction: Does this apply to companies authorized to do business in D.C. even as to their sales to D.C. residents made outside the District?)

Certain other states had close calls in 1985-86 with respect to attempts to impose restraints on AIDS underwriting. It is now quite apparent that there will be major legislative battles on antibody testing in 1987 in three major states -- Florida, New York, and Massachusetts.

On the other hand, some states not characterized by a powerful AIDS constituency, such as Oregon and Washington, seem to be supporting perhaps some enlightened underwriting approaches in the AIDS area. The NAIC, at the same time, is working through an advisory task force and trying to develop underwriting guidelines with respect to AIDS-related testing. It appears the NAIC will support antibody testing, strongly oppose "life-style," sexual-orientation underwriting, and permit questions about prior tests. The NAIC report will be very welcome to many insurance commissioners who are looking for guidance in this area.

What can insurers legally do in those states with testing bans to maintain some semblance of viable risk classification?

In the District of Columbia, there's probably not much that can be done; obviously, the ordinance invites massive adverse selection exposures. In California, insurers have the T-cell test available to them. That is an imperfect and somewhat expensive alternative. We also have careful underwriting techniques available to us (e.g., financial underwriting); but again, that has to be very carefully orchestrated because in California we have limitations on so-called "sexual-orientation" underwriting.

The underwriting pressures on insurers in test-ban states is the subject of a court challenge right now in California, where a domestic company, in an action brought by a national gay rights organization, is defending its practice of underwriting certain occupations more stringently than other occupations. California has regulations specifically prohibiting the use of sexual orientation in determining availability of insurance. This will be a key, watershed case in limiting or not limiting the reach of the California regulations.

Risk classification challenges aren't just showing up in connection with protected groups (e.g., unhealthy people, women, etc.). The principle is under an even more serious assault in our judiciary. A recent illustration of this occurred this spring in California.

A company had denied claim benefits due to clear misrepresentation in the application regarding drug and alcohol usage. The insured had died under the

influence of both substances. Even though the application clearly indicated that there was no drug usage and there had been no drug history, the jury concluded that the insurer had a duty to investigate possible drug usage solely because of the applicant's occupation -- he was a rock musician.

The dilemma posed to insurers is distressing: you can't use scientific, objective evidence for certain risks (AIDS, for instance); you can't use "sexual orientation" for any purposes; and yet you're obligated to use intangible life-style "hunches" to validate or invalidate statements on the application.

In short, the legal system doesn't offer us much solace. The basic legal foundations for testing and risk classification prerogatives aren't very clear. The Constitution doesn't talk about ELISA tests. Notwithstanding the "irrationality" of statutory prohibitions on testing, it is going to be very difficult to overrule legislatures in jurisdictions which adopt strict limitations.

Paradoxically, testing bans seem to violate fair insurance practice statutes existing in many states which prohibit insurers in the underwriting process from making any "unfair discrimination between individuals of the same class or of equal expectation of life." Paradoxes like that don't seem to bother legislatures much, and it is very difficult for the courts to reach solutions in such areas.

The moral of this story is this: Nobody really understands insurance except us; courts and legislatures aren't going to make decisions based on our rules and principles evolved over centuries, they are going to make decisions based on their perception of people's expectations and their perceptions of fairness.

This is simply an insurance manifestation of a major trend in the law of torts, contracts, and human relations as it has evolved over the past thirty-plus years. The courts are giving priority to people's "reasonable" expectations over the written word.

We in the insurance community can't ignore this. We must understand and adapt to it. We have to find ways to reconcile it with our underwriting principles.

The solution in the AIDS area, as I see it, is to effectively make the case that objective, scientific underwriting techniques (including antibody testing) are in the best interests of the entire insuring public -- including gay people, because medically valid underwriting is superior to erratic and unfair life-style underwriting -- and combine that with solid assurances and commitments about confidentiality and nondissemination of testing data.

Transamerica made a strong overture to the Medical Information Bureau a year ago to exclude AIDS and seropositivity from its system. The MIB was not receptive to this -- for eminently logical reasons; but, apart from logic, we felt it was a very pragmatic approach to dealing with the unique problems associated with AIDS underwriting. Currently, work is underway through the NAIC Advisory Committee to strengthen procedures for preserving confidentiality of test data. A proposal is under serious consideration whereby insurers would notify affected individuals if the insurers are ever the subject of subpoena by any governmental authority for the names of seropositives.

It is important to avoid polarization of insurers and AIDS constituent groups if we are to achieve a solution. Polarization leads to a District of Columbia-type impasse. If you watch those forces evolve, you can see how they give rise to the final result. That result is unsatisfactory for everybody. It's unsatisfactory for insurers. It's unsatisfactory for gay people in the District. It's unsatisfactory for the other insurance consumers in the District.

We are working very hard to achieve some sort of compromise in California. This would entail:

1. Allowing us to test in individual life/health insurance;

2. Strong guarantees of confidentiality, and something rather unique, which would not ordinarily be a part of the program, entailing perhaps a stop/loss or pooling arrangement for group health arrangements, aimed just at AIDS, financed by the State of California.

Let me talk for a moment about the politics of AIDS because, as with unisex, politics greatly colors the debate. Gay groups embody tremendous power/

influence in key states (California/D.C./New York). At the risk of stereotyping, the reasons for this are fairly obvious:

1. Wealth (It's not uncommon for gay people to hold positions of great economic import, responsibility, and respectability in the community. Often they don't have the same family requirements that others do.);

2. Single-issue focus;

3. Numbers (10% of American population).

The gay community is the single most powerful political element in California. We have on the ballot in November in California an initiative which would impose, it appears, severe restrictions on the health department with respect to their handling of the AIDS disaster. When initial polls were taken, it appeared that it had a 70-30 favorability. It now looks very convincingly as though the gay community, through a variety of efforts and avenues, will be able to overturn that.

In my judgment, doing battle in the political or the judicial arena with AIDS constituent groups over insurance issues doesn't make any sense. It's an undesirable (and, unfortunately, a too frequent) last resort. Not only is it difficult to win, but this is not the sort of subject matter that is typically handled well in the political or judicial arenas. Risk classification is like gravity -- it's just there. It's not something that you debate. But unfortunately for us, risk classification is much more difficult to understand than is gravity.

The federal unisex struggles of 1980-83 are a classic case in point. I was very much involved in the unisex effort and lobbying it with Ms. Lautzenheiser. We spent hours and days marching around Capitol Hill talking to one Congressman after another and one Senator after another. Apart from all the dialogue about insurance practices versus women's rights, that issue was ultimately won in the House of Representatives solely because enough members of Congress were convinced that a national system of unisex insurance would generate thousands of angry phone calls and letters from women drivers and fathers of teenage

daughters complaining about auto insurance rate increases. The sanctity of risk classification had nothing to do with the resolution of the issue at the federal level.

To pre-empt the political and judicial arenas it is critical to work out reasonable compromises which protect our underwriting mechanisms and simultaneously address the concerns of the AIDS groups. These things are not irreconcilable.

Early on, at Transamerica, we decided to play an affirmative role in the AIDS story. This was due to several factors, not the least of which was the geographical concentration of our business. From the premise that for insurance purposes AIDS is no different from any other disease, we reached two concrete conclusions:

1. AIDS is a challenge to our industry. If you think of it as a challenge, you approach it differently than if you think of it simply as a threat. We're in business to deal with things like AIDS. Life isn't just a series of improving mortality reports. If insurance works right, and pricing and risk selection work right, we can deal with AIDS. Our life and health industry can and should play a major role in confronting and managing AIDS and its consequences.

2. The right of insurance companies to classify and underwrite risk according to objective, legitimate criteria must be preserved.

In furtherance of both these notions, we were the first company to institute widespread antibody testing. Similarly, we have been active in trying to bridge the gap with AIDS groups and to bring some rationality and a spirit of compromise to bear on major issues. We've devoted considerable energies and corporate resources towards an enlightened response to the AIDS epidemic.

AIDS isn't going away. At a minimum it will be with us for decades. Either we find ways in the insurance context to deal effectively with it or we allow it to whipsaw us, jeopardizing individual company solvency and the fundamental way we do business.

If all this business about risk classification and challenges thereto sounds alarming, it should. AIDS just happens to be the most immediate issue. The public's ignorance of and skepticism for insurance, however, coupled with the trends in our courts assure that the challenges will continue.

Let me conclude with that observation, but also take the liberty of making a personal prognostication or two about the AIDS situation.

1. It is becoming increasingly important to resolve the underwriting dilemma in California. I predict some sort of compromise will be worked out in the next year or two requiring forward-looking approaches by the insurance industry.

2. It may not be the majority view, but I wouldn't be at all surprised if the infection levels of AIDS are beginning to top out. There is evidence that certain high-risk communities have reached saturation levels of infection. AIDS is rather difficult to contract, and there are signs that those most susceptible to it through their behavior are already infected. Clearly, education may well be playing an important role in stopping further spread. That does nothing about the one to two million people who are already infected.

3. The politics of AIDS and its implications for the insurance business will change dramatically if AIDS spreads to the mainstream heterosexual community in significant numbers. By the mainstream heterosexual community, I refer to men and women who would contract AIDS other than through sexual contact with the gay community and other than through IV drugs. The jury is still out on this question. I predict that if this broader infestation should evolve, the issue of antibody testing for underwriting will become a moot point very quickly and society will force us toward mandatory, government-sponsored AIDS testing of everyone.

MR. MINCK: Actuaries, of course, are a highly literate group. I've known at least three senior actuaries who had quotations from Shakespeare on a plaque on the wall in their office. Curiously enough, they were all from Richard III,

and it's Dick the Butcher's speech, "The first thing we do is kill all the lawyers."

MR. DEDERER: You'd have to do an awful lot of killing.

MR. MINCK: That's right. I suggest, for those who have the plaque in their office, you might put a little note at the end of it, "except for the ones on our side." The next part of the program is going to be a view from the position of the underwriter of how the future looks for underwriting.

MR. JOHN T. SNORE: When Mr. Minck called me a few months ago and asked me to participate in this panel, particularly to make some comments about the future of risk classification, I was really surprised and gratified, because I had just been on the telephone with some of our marketing people discussing some of the underwriting changes we had made in response to some of the problems that you have heard discussed here. Frankly, I wondered a little bit whether I had a future in underwriting at that time.

Mr. Minck's request about the future of underwriting seemed to be oriented toward the AIDS situation and what effect other types of legislative and regulatory activity regarding the underwriting of disabilities and medical impairments has had on underwriting. But I also sensed that he would really like to have a slightly broader view of underwriting presented here if I had one. I thought about that a bit and wondered, frankly, that since Ms. Lautzenheiser was the only actuary on the panel here today, I really ought not leave the task of commenting on the future to her, because I've always thought, and was always taught, that it was the actuary's job to make the predictions and it was the underwriter's job just to stick the risks into the appropriate classifications based on the predictions you folks had made. But after hearing what a doctor and a lawyer have said, I guess I can't resist doing a little predicting myself.

When one attempts to look forward, it seems wise to look back at what others were predicting about the future of risk classification just a few years ago and see how their thoughts matched today's reality. In the fall of 1980, Harry Garber presented a paper to several underwriting, actuarial and marketing

audiences in which he outlined his vision of what underwriting would be like in the eighties. His views rested on the assumptions that:

- Inflation would continue at a very high level throughout the decade.
- Mortality would continue to improve rapidly.
- The life insurance industry would become even more competitive than it was at that time.

Based on these assumptions he felt that the eighties would see, rather than a continuum of the evolutionary changes in underwriting that had taken place over the last 100 years or so, a dramatic shift in the methods we use to classify risks.

This shift would occur because companies would be more concerned about containing or reducing their rapidly rising expense rates, among them the high costs of individual life insurance underwriting, than reducing their mortality costs. Those high costs of underwriting were not only the out-of-pocket costs, but the high costs of the poor field and home office relations which often result from our turning away of customers because of underwriting barriers. He forecast, therefore, that the industry would move rapidly away from using the traditional tools of underwriting the life insurance risk -- medical exams, attending physician statements, ECGs, inspection reports and so forth -- because of their expense and inconvenience.

Harry also suggested that discontinuing the use of these information sources would result in our classifying risks much more broadly in the future than in 1980. We would have a wide standard class and perhaps only two or three substandard classes. Since we would no longer use our traditional underwriting tools, we would rely heavily on the agent to classify risks through the use of a very short-form application and provide better service to his customer by allowing him to issue policies on the spot if the proposed insured passed a few simple screening questions.

These steps would, of course, make the job of selling life insurance easier and lead to more new business for a company adopting this strategy, at substantially lower cost. The increased claims resulting from this less stringent scrutiny of applicants would be minor in their financial impact compared to the positive effect of large increases in sales coupled with significant savings in underwriting expenses. Thus, in the final analysis, there would be lower prices for the consumer and presumably an improved competitive position and increased profits for the insurer.

Harry was at least partially correct in the assumptions underlying his predictions. Price competition among life insurers is certainly hot and heavy as we enter this second half of the decade. Inflation, however, is no longer with us, and as a result we have not seen a dramatic change in the way the industry does its underwriting. After a spate of early 1980s increases in non-medical limits, ECG requirements, etc., underwriting information requirements of most companies have remained relatively stable for the last few years.

Harry was correct, too, when he predicted that mortality would continue to improve, though I'm not so sure that it is improving as rapidly as he thought it might. We estimate that the combined claim rates of companies contributing to the Society's annual study have continued to drop about 1% year to year on policies studied from 1980 through 1984 anniversaries, as opposed to 2% per year in the seventies. However, something that Harry didn't, and couldn't, foresee has arisen that very well may change that picture over the next few years -- AIDS.

In my own company this terrible syndrome has had a negligible effect on our mortality results so far. Less than 1/2 of 1% of our 1985 life claims, by amount, were on victims of AIDS and in 1986 it will still be less than 3/4 of 1%. What they will be in future years is difficult to tell, but it is certainly possible that they will be large enough to offset the general trend toward improving mortality we have seen among the population not at risk of AIDS. The potential for antiselection on future business by knowledgeable individuals who are at risk and the impact of that antiselection, if successful, on our mortality results, is tremendous.

Concern over this possibility has led many companies to add questions about AIDS to their application forms and to start doing routine age and amount blood testing for the HTLV-III antibody. These steps, obviously, have moved life underwriting in quite the opposite direction from the short-form, simplified underwriting that Harry Garber foresaw.

When one looks back over the past five or six years, the only change in underwriting during the period that might be termed dramatic has been the rapid spread of smoker/nonsmoker classifications. After 20 years of being out there all alone in giving life insurance discounts to nonsmokers, State Mutual found itself joined by the entire industry almost overnight. Underwriters, instead of classifying risk more broadly and simply, found themselves having something new to evaluate -- the question as to whether or not the proposed insured really was a nonsmoker. It didn't take long for many companies to find that they couldn't always rely on just the proposed insured and the agent to provide totally correct answers in regard to smoking habits. As the spread between smoker and nonsmoker rates has increased, so has the incentive to fudge those answers. It's very difficult to believe that 90% of those in New York City to whom we market life insurance are nonsmokers! This has led, of course, to the adoption of special underwriting questionnaires regarding a person's smoking habits and routine testing of urine for nicotine.

One other event that apparently wasn't clearly foreseen six years ago was the unbundling of our products. This change in product design makes it possible to much more easily compare one company's mortality and expense charges to another's at the point of sale. This has put additional pressures on underwriters to produce better mortality results than the competition, while at the same time doing so in the most efficient manner possible. These forces have worked against our abandoning our traditional underwriting approaches and they have also forced us to rethink our overall pricing techniques and reconsider how finely we should classify risks.

For example, the increasing importance of being able to cite low mortality costs in the sales process has prompted a number of companies to go even further in attempting to select a preferred group of customers. We now see the development of super-preferred classifications for individuals who don't smoke,

have wonderfully low blood pressure, no medical histories and white collar occupations, and who are able to swear to the fact that they exercise three times a week at Jack LaLanne's. Thus, we seem to be moving toward obtaining more underwriting information, not less, in order to be able to place individuals in these more finely delineated classes. In my own company we have moved from 10 classes (preferred, standard, eight substandard) in 1980 to 19 today -- all but the preferred classes are divided between smokers and nonsmokers -- and we're thinking of adding more in the future.

You can't accurately place risks in finer and finer classes without information. We recently revised our application form to include more questions -- not specifically about AIDS, but about driving, avocations and more detailed medical questions about other types of medical problems. Naturally, the more information you obtain from the proposed insured, the more likely you are to request information from other sources to clarify and verify it.

The same is true about underwriting of substandard risks generally. Intense competition has forced finer and finer classification of substandard risks. Some types of malignant tumors are now subdivided into four or five rating groups depending on how the pathologist classifies the tissue. Other examples include individuals with coronary artery disease. Heart attacks are now finely graded by severity, and heart disease treated by bypass surgery is charged an extra premium depending on the number of diseased vessels. The original purpose of these distinctions was, of course, to give a little lower rating to what were perceived to be the very best risks in each of these groups and, therefore, take some good business away from the competition. While this strategy may have been successful, at the same time it has led to more complexity in the underwriting process and pushes all companies to obtain more detailed, not less detailed, underwriting information than was the case just a few years ago. (By the way, I hope we know what we're doing in this area; my own experience is that what the medical profession subjectively believes to be the best or worst cases when it comes to the long-term prognosis of some medical impairments is often not supported by the actual results that emerge.)

Why have I been talking about Harry Garber's 1980 ideas and the fact that we have not seen the dramatic changes in underwriting he predicted? Because,

frankly, even without them I still see the underwriting future as one full of exciting challenges such as:

- Finding ways to successfully protect ourselves against antiselection on future business on the part of those in our population who are at high risk for AIDS.

- Persuading legislators and regulators that a "free market" approach to risk classification is, in the long run, in the best economic interests of our current and future policyholders and that simple equity requires that each policyholder pay a premium commensurate with the risk he or she represents.

- Finding ways to improve underwriting service to our customers, and at the same time improving the cost effectiveness of our operations while controlling our mortality costs.

Will we be able to meet these challenges? Yes, I think we will.

While I believe that as we move into the 1990s life insurance underwriting will be done in much the same way it was in 1980 and is done today in 1986, we will see changes. I suspect, however, that those changes will be a continuing evolution of current and past underwriting techniques rather than any radical shifts in practices. I believe that the current trend of subdividing what was our rather broad group of standard policyholders into a variety of super-select classes, in order to penetrate certain market segments more effectively, will probably continue; but the information we use to make these increasingly subtle distinctions will be much like what we have today: medical and paramedical exams, ECGs, urinalysis, attending physician's records, blood tests and so forth. We will undoubtedly see improvements in these techniques. We've even seen a series of tests claimed to accurately predict an individual's biological age. My guess is they won't be that much different, just as they aren't that much different today than they were almost 30 years ago when I started out as an underwriter.

I also believe that these same techniques will protect us against the AIDS epidemic, unless it moves out from the high risk groups and spreads rapidly through the general population. If that happens, we're all lost, so underwriting won't make much difference.

It seems likely to me that we will be as successful in maintaining our relative freedom to classify risks as we wish -- except for sex, which I'll leave to Ms. Lautzenheiser. I'm not so sure we'll prevail there, but after 15 years of involvement with legislators and regulators, I don't see any great desire on their part to really put shackles on our other risk classification activities.

Occasionally they respond to pressure from one particular group or another -- the blind, who complained about how we treated them, and not without reason in my opinion, which is why they prevailed. Or gay rights advocates who took some legislative bodies by storm and managed to secure legislation restricting our underwriting freedom in California, Wisconsin and the District of Columbia even though we had sound arguments on our side.

We will continue to develop and utilize new technologies, however, to make the underwriting process more friendly to our agents and their clients. Here, I'm thinking of digital imaging and a paperless environment as well as expert systems utilizing artificial intelligence to help us speed up decision-making and reduce our handling costs, for as Harry Garber pointed out six years ago, in order to be financially successful it is, and will continue to be, necessary for all of us to get large amounts of soundly underwritten business on the books as inexpensively as possible.

MR. MINCK: It's always good to hear from the underwriters. Barbara Lautzenheiser is going to give the view of the actuaries.

MS. BARBARA J. LAUTZENHEISER: All of you have seen, and I'm sure have watched, the elaborate systems by which you have a series of dominoes, push only one, and an intricate pattern forms. Bells go off, whistles go off, everything looks fantastic. It is really quite fun and intriguing to watch those patterns as they occur. However, I think it's going to be not fun but

frightening to see those dominoes take out our elements of risk classification and the pattern that is being formed by their elimination. I'm not as optimistic as John is that we aren't losing some of our abilities to classify risks.

Sixteen years ago, when I was at the Bankers Life of Nebraska, the chief underwriter came into my office one afternoon and said, "I just had an interesting luncheon conversation. I went to lunch with the woman who is head of the Epilepsy Foundation, and she told me she didn't think it was fair that she had to pay more simply because she had epilepsy. After all, it wasn't her fault she had epilepsy." Bells and whistles went off for me as well, because all of a sudden I realized that's exactly what I had been hearing in the women's issues -- that it wasn't their fault they were women. Hence, they should not have to pay more for their disability insurance and annuities, which were the two issues that started out the unisex issue. I sensed we were going to have problems on risk classification if, in fact, we did not take a stand on the unisex issue, where we had a large volume of data showing the mortality differences. Without a stand we would then lose on faultless medical impairments when we didn't have all of that data and all of those statistics. Sixteen years have gone by, and things are still moving down that path. The trend is even moving further.

The unisex issue is not over yet. Yes, we did win at the federal level, and we walked an awful lot of halls in Congress to do that. On March 28, 1984, the House Committee on Energy and Commerce amended H.R. 100 to apply only to employers, and with that we ended up really killing the bill. It has been brought up a couple of times at the federal level, but it lies pretty dormant, and I am even told that the women's groups don't even talk to one another about it any more. So I think at the federal level we may have won the issue.

It doesn't seem to be totally won, however, in the states. Montana, as you know, has passed legislation. We attempted to get it repealed. We lost by two votes in the Senate. It went into effect in October of 1985. There was a mixed reaction by the companies there, partially because Montana's population density is relatively small, and large numbers of companies were not writing substantial amounts of insurance there. Some companies developed unisex rates; some companies raised the rates to the higher of the two gender-based rates;

some companies withdrew policies; some companies ceased writing completely; but it was not anything that was dramatic enough to point to and say that's what is going to happen.

The Supreme Court of Pennsylvania indicated that, in the absence of clarifying legislation, the state's equal rights amendment could be relied on by the insurance commissioner to require unisex rates in property-casualty insurance. The insurance industry (property-casualty) went back and got the Senate and House to pass that clarifying legislation, only to have the governor veto it and then to have to go back and get an override of the governor's veto, which was done. We have two court cases pending in Pennsylvania to test that particular clarifying legislation.

Our biggest concern on the unisex issue still lies in Massachusetts. Much to the surprise of the lobbyists as well as many of us, a Massachusetts unisex bill did get out of committee and to the floor of the House; and on July 3, 1986, one day before the anniversary of the nation's independence, our independence in classifying on gender was threatened, when the bill passed. It is coming up before the Senate this fall, unless it can be contained in committee. I do urge all of you to have your policyholders and agents write to Senators. Coordinate that with the ACLI, because they have a specific timing on which they want that. Again, I urge you to have your companies do that, because it is a very critical piece of legislation. If in fact it were to pass in Massachusetts, we would then have two states with unisex in all lines; and it could open that unisex door completely.

Mr. Snore, I believe, is sounding like the Office of Federal Contract Compliance people did back in 1974 when they said, "Why don't you (the industry) give up; unisex is inevitable." My answer was and is that I can guarantee one thing. If we give up, it is inevitable. We haven't given up, and we've contained it fairly well. We do have one additional problem in Massachusetts, and that is that one major company, The John Hancock, is taking a position for prospective unisex legislation. So we do not have the united front Jim Dederer talked about that is really necessary if we are to win these political battles. And that is what we are doing -- fighting political battles.

Unfortunately, when I had that fear when Paul Blumer came into my office 16 years ago, and I prophesized that it was the beginning of the ending of our risk classification ability, I wasn't a babbling idiot. I was instead a prophet, because that is the direction it has gone. Mr. Dederer and Mr. Snore both talked about blindness. Mr. Snore has testified on the blindness issue. In both the 98th and 99th Congress, blindness legislation has come up at the federal level. During the 98th Congress we moved the issue back to the state level, where the National Association of Insurance Commissioners proposed amendments to its model regulation. Twenty-four states have adopted that new version now, but the issue popped right back up in the 99th Congress. We have amendments developed. The sponsor of the federal bill has agreed to accept those amendments, except, now, Congress is about to go out at the end of this week; nothing may occur on it. It wouldn't surprise me if it came right back up in the 100th Congress with all the bad pieces in it that it had before, including punitive damages and the inability to underwrite for blindness even when it was part of diabetes. So the second of those threatened risk classifications is blindness.

Now we get to the third of those risk classifications, and as you are beginning to see I am identifying a trend. We do look out the back window of our car, don't we, as we identify our mortality rates? We also need to look out the back window and see what has happened to our risk factors and pay attention to what is going on because that third factor is a very serious one. It is that medical impairment I talked about 16 years ago. It is one none of us could have seen before the 1980s, but maybe should have seen in 1981 or 1982. Conversations about AIDS had started then. I won't ask you if you heard anything about it or cared anything about it as actuaries in 1982. Maybe if we had, we could have been doing something about it at that point in time. I suspect that we, including me, didn't even know about it.

The initial concerns on the AIDS issue had to do with the alleged lack of credibility and validity of the tests. We've pretty much taken care of that now. Even the gay community will accept the credibility and reliability of the tests as the result of some very good work of the Wisconsin state epidemiologist -- and I think Bob Gleeson did a fair amount of work with him on that -- and the work of such eminent AIDS researchers as Dr. Robert Gallo, saying that

the series of tests is 99.9% reliable. There are those in our industry who say they are probably the most credible tests we have. I understand treadmill EKGs are only around 60 to 90% reliable.

The opposition to AIDS testing began with doubts about credibility of testing, and a lot of this legislation that came about was passed before the reliability was established. Even the judge ruling on the litigation filed by the ACLI and HIAA on the D.C. bill came out and said that in the light of this summer's report by the Wisconsin state epidemiologist the D.C. Council "should be encouraged to reconsider its decision." A lot of this is a matter of timing, but they are pushing us before we have all of our ducks in order, which means we really need to get our ducks in order today, because I don't know what is going to come next.

Does AIDS have a substantial mortality and morbidity impact? Seventy-five percent of the AIDS patients diagnosed prior to January 1984 are now deceased. Ninety percent are dead within one year after getting an opportunistic disease (that is a disease that wouldn't normally kill, such as pneumonia). The latest CDC figures say 20 to 30% of those infected with the virus will have AIDS in a five-year period. One study of a group of New York homosexual men followed for five years showed 34%. The percentage of infected people who will get AIDS is actually projected by Dr. Anthony Fauci, Director of Clinical Research on AIDS at the National Institutes of Health, as perhaps as high as 40%. I have my actuarial concerns about even that being too low. We've heard about the underreporting. The CDC says it is 10 to 20%. A *New York Times* article reported on interviews with doctors. Doctors do not want to report AIDS for fear of hurting the family. If you go back and review a lot of your claims, you will not find AIDS, but you will find the symptoms. A lot of companies who have gone back and done that review have found that there are AIDS deaths that don't say "AIDS deaths."

If there is that kind of underreporting, the numerator of that 20 to 30% fraction is significantly smaller than it in fact should be. What about the denominator? A couple of months back I gave a speech at the Conference of Insurance Legislators, and a nurse at a New York hospital said to me, "Barbara, your numbers aren't good because that denominator (she didn't call it that, she

referred to the number exposed) has been overstated because they were tested by only one ELISA test instead of a three-step protocol." I don't quite know how many that is. Dr. Gleeson says he thinks that we went to the three-step protocol fairly quickly. Even if there is any overstatement of the denominator and an understatement of the numerator, you know what that does to the percentage of 20 to 30%. It increases it. We have possibly even larger problems than we thought before.

Dr. Gleeson indicated it was a chronic condition. Once infected, a person is infected for the rest of his life. HTLV-I and HTLV-II are associated with cancer, and it is suspected that HTLV-III will ultimately be as well. There may be more degenerative impact beyond AIDS. It was recently discovered that many others with the HTLV-III infection (and by the way, we are now beginning to call it HIV) who don't develop AIDS or ARC are going to develop AIDS dementia, a disabling of the central nervous order. Dr. Rhame, of the University of Minnesota, said that as many as 60% of those infected by HIV will develop within ten years dementia of such severity as to be permanently disabling. We've been talking mostly about costs of health care and costs of life insurance. Those of you who write disability income ought to be seriously concerned also.

One of the problems of this disease is that the average latency period is four years. It can go as high as seven. We've only traced it back about seven years in this country. They are beginning to predict effects ten and twenty years down the road. We don't even know what we have. Those of you who are seeing some AIDS cases in your companies, other than the antiselective ones that you find as a result of testing, are finding some of these cases are coming out of 1982 and 1983 issues as a result of that average four-year latency period. We haven't seen those from 1983 and 1984 and 1985 issues yet. We may not for some period of time. But they are, unfortunately, there. Simply put, if you are an infected person, you are at a higher risk; and, as I say, even the gay community is beginning to accept that fact. My biggest fear is that the AIDS virus is the tip of a giant iceberg even bigger than AIDS.

Again, the CDC projects that 20 to 30% of infected persons will get AIDS within five years. Those with AIDS usually die within two years. Take a seven-year

period. A male age 30, standard risk, right now has less than a 75/100ths of a percent chance of dying in the next seven years. That means AIDS virus infection, at a 20% probability, is 2600% times standard. That's the same as issuing insurance to a person over age 70 at a 30-year-old's price. This may not be age discrimination, but when you put it that way, it sounds a little scary. It doesn't take very many cases with an expected mortality of 2600% to impact the claims, and 2 to 4% on an annual basis can add up to 35% in five years. I'll give you a little feel for that 2600% compared to other diseases. Quadriplegia is 750%, myocardial infarction is 500%, diabetes is 400%, smoking only 200%. AIDS virus infection, even at the lower projected 20% level, and there are those who project 30% or more, is a 2600% mortality risk.

We've seen a fair amount of exposure already in companies. Kemper began testing in November 1985. Adding this test to all of their other blood tests on medically underwritten lives, they identified 14 cases in a two-month period. Only two of them were in a high-risk group. Of the other 12, one was a female, and 11 were married men with children. If you think you don't happen to be underwriting or writing in a market that is a high-risk group, and hence your company is not at risk, I suggest you are fooling yourselves.

Home Office Reference Laboratory reports 61% of their positive findings are in non-high-risk areas. By 1991, CDC projects that more than 80% of the cases are going to be outside of New York City and San Francisco. Transamerica's total life and health claims are already more than $4.6 million. In the first eight months of 1985, 3% of their claims were AIDS claims. General Reassurance had 4.5% of their claims AIDS claims already in 1984. So the numbers you are seeing from Northwestern Mutual and the Prudential sound relatively small compared to what we've already seen in other companies.

We are also seeing antiselection. Transamerica is seeing policies applied for that are 2-1/2 times average policy face amount. You heard the Northwestern Mutual figures. The ACLI/HIAA report that you received indicated that, of the AIDS death claims identified, 44% of them (by amount) were still in the contestable period. Of course, AIDS is not just an antiselection problem, but also a problem that is already in the in-force.

In some instances, in those states where we can't do testing, we run the risk of people moving to those particular states. We also have pieces like a San Francisco Department of Health pamphlet saying, "We urge everyone to maintain adequate health insurance."

The real problem with all of this is that, as Jim Dederer pointed out, it has nothing to do with logic, it has nothing to do with risk classification, it has nothing to do with true financial costs; it has to do with politics. The gays are concerned about testing partially because they want health insurance, partially because they want life insurance, but mostly because they are concerned about confidentiality, concerned about their names appearing on a list, and concerned about quarantine. Dr. Gleeson has said that if in fact this builds to the level he expects, that they probably have rightful fears. I wouldn't disagree with him. Their fear level is about a 16 on a scale of 1 to 10. There are six states that already require reporting. Some states have passed legislation, and in others there is proposed legislation for quarantine should the health department find it necessary. Several states actually have legislation that makes it a criminal liability to knowingly transmit the disease. In our nice little cocoons, we don't know these things are out there. The gay community has reason to be afraid. Maybe we do too.

As Jim has pointed out, the gay community does have a lot of political power. They are very well networked. They have people placed in very high positions. One of the members of the gay community said, "Don't you find it interesting that the health departments all seem to be on our side?" (He had a big smile on his face when he said it). Jim pointed out some of the comments that were made at the D.C. legislative hearing. Another comment was, "Do you discriminate on the basis of multiple sclerosis?" I personally find it amazing that the Cancer Foundation or the MD or MS Foundations haven't already walked into the District of Columbia and said, "Why do I have to pay more when those with AIDS infection don't?" or "Why can't I get insurance when those who are infected with the AIDS virus can?" It's possibly only a matter of time before they do.

Is the third threat, of AIDS, the last threat? I don't think so. Think about those two court cases in Pennsylvania that I said were unisex cases. In one

the League of Women Voters and the parents of a young male are charging that young males have to pay too much for their automobile insurance. In the other case it is said that elderly women have to pay too much for their automobile insurance. It is not male and female. It is young male and elderly female. It's age as well as sex. There is a lot of power in the gray panthers, and we haven't seen all of their power exerted yet.

The public doesn't understand insurance. It doesn't understand how we price. It doesn't understand risk classification. What we are seeing are some of those trends that the ACLI's TAP report described back in 1970, saying that there is a psychology of entitlement: insurance should be provided to all at all times. What does happen when we can, as Mr. Snore indicates, underwrite even more specifically? *Business Week*, November 18, 1985 asked, "Do you feel that insurance companies would be justified or not in refusing to insure the lives or health of people whose gene tests indicate they are likely to come down with a fatal disease later on in life?" Do you care to guess what percentage said we would not be justified? Seventy-five percent said we would not be justified. We don't exactly have the public on our side.

It is imperative that each and every one of you do whatever you can within your companies and outside your companies to educate the public on insurance and on risk classification. I guarantee you it will be a long-term problem, and you are also going to have to learn to fight those political battles in emotional arenas, rather than logical arenas, and keep disaster away while you get that education done.

MR. MINCK: If I can be indulged, I'd like to have a commercial before we go into the questions and answers. The industry organizations have been involved in a couple of things to approach this problem that Ms. Lautzenheiser has been talking about. One is preparing a short film on risk classification that we will make available to companies and to individuals, for the cost of the tape. It may be suitable for use with various sorts of local organizations that you may belong to. We also are going to start an advertising campaign over the next year. I think we have budgeted several million dollars to try to bring the importance of risk classification across to the public so that the discussions will take place in a somewhat more informed atmosphere.

On the question of AIDS we have contributed, as have many of our member companies, to different aspects of the problem. Regarding one that Ms. Lautzenheiser mentioned, dementia, we have put some money in a study that is being done by the University of Alabama and the Sloan-Kettering Institute to try to get a handle on the problem. Again, I think it is the sort of thing where your companies can find opportunities and ways to participate. We all have something at stake. It would be helpful if you would.

MR. HARRY A. WOODMAN: I certainly agree with the panel's concern about this problem. In particular I agree about the understatement of the numerator in claims reporting and also about the tip of the iceberg that Barbara mentioned. I would like to make two observations, however, which suggest that the problem may not be quite as dismal as has been suggested for us. I make these with a certain concern that this may be taken as downplaying the problem, which I don't want to suggest. In any event, the proposed insured population that we deal with, I suggest, has a lower-than-average percentage of intravenous drug users and promiscuous homosexuals, who are the primary risks for AIDS. So that's a blessing for us. Also, Dr. Gleeson mentioned average AIDS claims of $70,000 as compared to the average claim overall of $19,000. The AIDS population really hasn't matured. When we looked at claims by duration, we found that the average size of the AIDS claims only very slightly exceeded the average size of other claims.

MR. ALAN N. FERGUSON: I'm with Blue Cross and Blue Shield of Michigan. You might ask what I'm doing here, because we are not allowed by the legislature in Michigan to do any individual underwriting. In health insurance we don't rate by age or by sex or by health. The consequences are pretty obvious. We get the older and the sicker ones.

I would like to direct your attention to a related problem that I would like your views on, and it is connected with wellness -- the problem it may pose for the pricing of not individuals, but large groups. It is being suggested that wellness is within the control of the individual employee, and that the contribution which the individual employee makes should perhaps depend on wellness status. So I would like to ask your opinions of the feasibility that the wellness status would be based on controllable conditions; i.e., smoking, seat

belts, weight, blood pressure, and not the uncontrollable things such as AIDS, sex, blindness, epilepsy, etc. In particular, you might want to consider the feasibility of applying some of these tests, in particular in view of the fourth amendment. I wonder how invasive it is to make sure that the urine specimen you are getting to test for drugs is from the person you are actually testing.

DR. GLEESON: It is fine to measure certain things for wellness, but I don't know how you are going to separate wellness from underwriting, if you are not allowed to underwrite on individual characteristics. You have to underwrite on quantifiable things. You can check the urine for nicotine. I don't know how you guarantee someone is wearing seatbelts. I don't know how you guarantee that somebody jogs. We also have to remember that the big wellness boom or the big running boom of three years ago has petered out. Walking is in. We are now saying that people who run more than three miles three times a week are doing their body more harm than good. So I think you have to look at things from the overall perspective. I would take only adverse characteristics, like smoking, and look at them.

MR. FERGUSON: I have just a comment on your distinction between underwriting and wellness classifications. Whereas the legislature, responding to individual circumstances, may say, "you may not underwrite on the basis of individual health, etc.," I think they may very well respond to larger employers wanting to cut health care costs by achieving a better level of wellness, by having nonsmoking campaigns, and having people who do not smoke. In a state that has very large employers the legislature may approve such distinctions.

MS. LAUTZENHEISER: One of my major concerns is that as we begin to move into determinations of controllable and uncontrollable and causative kinds of factors, those distinctions become very gray. I frankly blamed my parents for my obesity for a long time. There are studies about the possibility that children may be born more prone to smoke than not smoke. You end up just moving a lot of the argument to yet a different phase. It is going to be very difficult to say anything is controllable if we start moving toward that determination, I fear.

MR. MINCK: Pursuing Dr. Gleeson's point, I suppose it is possible to keep track of things people are doing that would adversely affect them, because if they stop, they'll report their actions and you'll get a chance to do something about it. Keeping track of whether or not they fasten their seatbelts and other things may be more difficult, because they may not tell you if they've stopped.

MR. JOHN F. RUDIN III: Does the ban on discrimination on the basis of sexual orientation prevent us from, rating for promiscuity as reflected by the presence of a sexually transmitted disease?

MS. LAUTZENHEISER: A sexually transmitted disease is a medical condition. It sometimes happens as a result of promiscuity, but it is not necessarily a result.

MR. RUDIN: Would the courts look at that as trying to discriminate against gays without saying so?

MR. DEDERER: I don't think there is anybody who can realistically say what the California courts are going to do in any situation. My reading of your question is that you have a very strong argument that the ban on sexual orientation underwriting would not apply in that circumstance.

MR. MINCK: Yes, particularly if you refuse to issue to anyone of any sex, age, or condition who has a history of syphilis or who is currently infected.

MR. DEDERER: I think you take yourself out of the prohibition there.

MR. RUDIN: My next question is whether there is any difference in fact between maintaining confidentiality and making it as easy as possible for someone who has been turned down to get insurance from another company.

MS. LAUTZENHEISER: My sense is no. Again, the confidentiality question is really one of having a list somewhere. What kind of list that is is irrelevant. It is just the fact that a list exists within insurance companies, within MIB, or wherever, that can be subpoenaed by Congress or by a Department of

Public Health for the purpose of quarantine. That is the number one consideration. The presence of a list and the identification of these people for incarceration is the concern.

MR. MINCK: You might have both things flowing as consequences from the same sort of action, but I think Ms. Lautzenheiser is correct as I understand the motivations of the people involved.

DR. GLEESON: By the way, the concerns about quarantine are not our concerns. They are the concerns of the gay rights movement that Ms. Lautzenheiser and I have heard at NAIC AIDS Advisory Committee meetings. The gay rights movement is definitely concerned about a move to quarantine their own membership.

MR. CHARLES A. VON FAGE: There is a source of information on AIDS that you may not have seen, because it is a rather unusual topic for this publication. In the June or July issue of *National Geographic*, there is about a 20- or 30-page spread on AIDS and the immune system. It is very well done. Also, about two weeks ago there was an article in the local newspaper about some advances in cancer research that seemed to be tying in the knowledge that had been gained from studies of the immune system that were fostered by the AIDS epidemic, leading to some possible breakthroughs in research on certain types of cancer.

We were talking about the smoker/nonsmoker risk classification. My observation is that our preoccupation with finetuning the smoker/nonsmoker classifications into smaller and smaller groups, primarily for the purpose of finding some way to be yet more competitive on price, is getting to the point of being somewhat silly. We really are at the point of essentially putting a telescope on a shotgun. The data base from which a lot of us are extrapolating to draw these kinds of conclusions may have changed. That data base was created about ten or fifteen years ago by a few pioneering companies. The smoker and nonsmoker populations have changed since then. On another matter, perhaps we have already issued coverage to a majority of the people who have been infected with AIDS but do not yet show symptoms. We may already be on the risk for those people.

MR. MINCK: I think we are on the risk for a lot of claims.

MR. ALBERT L. PERUZZO: There have been a couple of articles in the *Wall Street Journal* over the last year that suggest that in the short run (not the 10-year horizon, but the 5-year horizon) there seems to be a strong correlation between stage three, actual AIDS, and a high rate of substance abuse. I wonder if any of the panel would care to comment on that.

DR. GLEESON: That opinion is held by a doctor from Washington, D.C., and is not shared by any other member of the AIDS medical establishment. The theory had its stronger stance early in the epidemic, when we thought that there may be co-factors responsible for some people developing AIDS at a higher rate than others. We knew less about the virus then than we know now. The issue is still not resolved totally, but I don't know of anyone doing major research in this area. The disease is caused by a virus, and I believe that the virus is so incredibly potent that you don't need anything other than the virus to cause death. If you have a weakened immune system from another cause, it's going to happen sooner or faster.

MR. FERGUSON: I was at the mortality committee meeting on Sunday when there was a brief discussion of recent mortality results, smoking versus nonsmoking. Harry Woodman, who is chairman of the committee, probably knows the facts better than I do. But I understand that based on the first three durations in the intercompany study, the results show that smoking mortality ratios are double the nonsmoking mortality ratios.

MR. SNORE: It is clear that at the Prudential smoker mortality is essentially double that of nonsmokers. It is true at all ages and all durations.

MR. PHILIP J. BARACKMAN: Another aspect of risk selection is the selection of what geographic areas to target-market. Obviously this is something we can do by zip code selection as part of our segmentation process, identifying which segments of our market are most profitable and give us the best experience. Is anyone else concerned, other than me, that the NAIC proposal may contain restrictions on the right to use zip code selection for a direct mail solicitation? I would like your reaction either disabusing me of what I received

secondhand or substantiating that and any comment on this assault on a free market principle.

MR. MINCK: At the most recent meeting of the NAIC Advisory Committee, the industry representatives who were present argued very strongly for exempting mail-order operations from the sort of restrictions that were being placed on geographic area. The argument was basically that you can't run a mail-order operation with very expensive or extensive underwriting. If something shows up in the way of a negative response, you really have to turn down the application. Correspondingly, the great secret to operating successfully a mail-order operation is in selecting the segments of the market to which you are mailing, because of the need to get good response rates. The folks speaking could see that there were great difficulties if you once got the idea that not mailing to a particular zip code area was a prima facie case of discrimination. The people representing the gay community, I think, were not completely convinced. I think, therefore, the danger exists, but you are certainly not alone in your concern, and everything that I can think of that the people representing the companies there could do was done. I think it will continue to be done.

MS. LAUTZENHEISER: I think the key there was in the thrust of the guidelines that the Advisory Committee is developing. They say that zip code cannot be used to determine sexual orientation. The issue we talked about on direct mail was that we had to be able to mail only to those areas where the costs did match the pricing and really base it on costs, and that we weren't basing it on sexual orientation. The real key in those guidelines is elimination of discrimination on sexual orientation. We had an understanding of the gay community there, but they were still nervous about that.

MR. JOHN E. BAILEY: I know this is billed as an underwriting session, but there are other aspects of the AIDS problem. If the course of the disease is as bad as has been predicted today, and I personally believe that it is, we need to think about pricing and reserving, particularly for business that is already on the books. I'd like to ask if any of the panel have given consideration to that. What steps have they taken, and what do they think might be possible?

MR. SNORE: This question was asked of Bob Hill at our senior officers' meeting last week, and his answer was that we have a lot of surplus.

MS. LAUTZENHEISER: I believe the Society of Actuaries as well as the NAIC is trying to see if we can't quantify something.

MR. DEDERER: I believe the ACLI survey on that issue came up with only three companies, out of several hundred, that had established extra reserves.

MR. MINCK: Yes, that is correct. This is a very difficult area in which to do much in the way of investigation or discussion, the laws of the United States being what they are.

MR. MORRIS J. WERNER: I thought you might like to know something about the Australian scene in regard to the underwriting questions. First, we do have AIDS in Australia. We are getting experience underwriting it in our companies. I think one of the biggest concerns is that the gay community has made it very clear and advised all of its members that if you think you've got AIDS, before you have any tests for AIDS, you go and get some life insurance. I don't know how we are going to underwrite that sort of situation. Another aspect is that we do have legislation in place in a number of states which outlaws discrimination on the grounds of physical or mental impairment. Life insurance at the moment has got an exemption provided that we can show that the discrimination is based on actuarial or statistical data on which it is reasonable to rely. We haven't got any looking-back experience, and all the extrapolating that we are doing as to what might happen is going to make it very difficult for us in Australia to really classify AIDS people in the way in which we believe we ought to in the light of the information that you've got. Otherwise, of course, we are also in trouble on other physical and mental impairments, needing to rely on statistical and actuarial data. As far as we're concerned, a lot of our underwriting is based on manuals that have their origins back in America. There are a lot of people in Australia who argue that it is not reliable data for the Australian scene. The actuarial fraternity has got a big problem in trying to start studies on which we can base our own conclusions about impairments.

MR. MINCK: It's comforting in a way to have common suffering. I hope we can do something that will be helpful to you sometime.

MR. GLEN D. KELLER: I would like to clarify a point. Are you saying that 20 to 30% of the people who test positive on the Western blot test will develop AIDS within five to seven years?

MS. LAUTZENHEISER: Within five years, yes.

MR. MINCK: That's based on a complete protocol of tests.

MR. KELLER: I have a question concerning the quarantine issue. Given that it's pretty clear that AIDS isn't transmitted by daily activities, why is the gay community making an issue out of quarantine?

DR. GLEESON: When human beings are aroused to fear and anger and want to protect their own families, they act irrationally. Quarantine is an irrational act that will not help us. Ms. Lautzenheiser listed some states which, while they are not moving to quarantine, have laws that could be interpreted more broadly than they are currently being interpreted. In California, you have a possible quarantine initiative, Proposition 64, on the ballot. We are facing a major problem in the society. We don't need to panic, but we do need to be educated. I am terribly frustrated that the American public and the American Public Health Service have not provided adequate education to this country. I think it is absolutely criminal that today in America 500 to 1,000 people will become infected with the virus. People who were not infected this morning will be infected by tomorrow morning. If you take any sort of number close to one million and have it double in the next two years, which is slower than the Public Health Service is predicting, you have to have a couple of hundred people getting infected today.

We have to get realistic about this epidemic and stop it. I am afraid that the gays have kept the information about the epidemic inside the gay community. The Public Health Service has said, "Don't worry, you're not going to get it." What we will find out by 1991 is that we are going to have 50,000 Americans dying from this disease in that year alone. Do you think America is going to

sit here and calmly take that? No! We're going to go nuts! People have to be realistic about this, but what we are going to do when we decide to get excited about the disease is that we are going to go crazy. We are not going to get educated in a rational manner.

MS. LAUTZENHEISER: The tendency now, as Mr. Dederer has pointed out, is for a political solution and not a logical solution. You get in that kind of an epidemic environment or even close to it and it becomes even more political. The political solution is to take action, even if it is not reasonable action.

MR. DEDERER: In that context, assuming we ever get to that point, which heaven forbid, the way quarantine will be visualized is not to deal with the casual transfer of AIDS, but rather to take these people out of sexual circulation. That will be the rationale, and that's what the gay community is concerned about. The quarantine won't be because they have leprosy and things like that. It will be to take them out of circulation with the rest of humanity. That is not an unexpected result of the fear that would arise in the event this thing does spread to the heterosexual community.

MR. MINCK: I think there is a level of this sort of activity that historically has led at a certain point to irrational behavior.

MR. RAYMOND J. FOREMAN: In the U.K. we have gay communities as well. But I think we are fortunate that you are, say, three or four years ahead with this disease. We also have a public which is not very much aware of risk classification. The gay community and other communities are not really pushing, and they have no sort of power to attack the life insurance companies. The reinsurance companies have got the life companies to agree to a standard question on asking whether applicants have been tested for AIDS or whether there is any suspicion of AIDS. Most of the companies are agreeing to set up that question. We're also tabulating the deaths from AIDS, and we go through claims to see whether, in fact, it could have been AIDS, but may have been classified as something else. We've only had, I think, about a hundred deaths, but the main thing is that we've got no evidence as yet that there has been

antiselection against us at all. I think next year we will have built up more data, and perhaps we could share our experience with you.

MR. MINCK: We would be very happy to have it, and we thank you.

MS. LAUTZENHEISER: Does your medical system make needles freely available, so that you do not have a risk within the IV drug abuser community? I know Canada has virtually no cases from IV drug abuse because they do have access to free needles and are not sharing needles.

MR. FOREMAN: Yes, I don't think the drug abuse is the same in the U.K. as in North America. I believe that the health service is prepared to give clean needles, as it were, to drug addicts. They can get some rehabilitation with their doctors, who will point them in the right direction.

MS. LAUTZENHEISER: One of the numbers that is very sad to me is the 3,000 children they are projecting by 1991 to have been diagnosed with AIDS as a result of mothers having become infected. Most of those mothers contracted the virus from intravenous drug abuse.

MR. ARTHUR L. GARRISON: If the virus was a mutant in the 1970s, have there been any studies for possible further mutations such that it may be communicated in an easier manner, Dr. Gleeson?

DR. GLEESON: We certainly hope it does not mutate to become airborne, as there would then be no question about the seriousness of the epidemic. It is quite clear that the disease is probably not even borne by mosquitoes. While you may be able to find the virus inside a mosquito, we do not yet have a vector, a mosquito or bedbug. If mosquitoes carried the disease in Africa, the children would be infected. They are not infected, except those born to mothers who are infected. The eight-year old boy or girl is not infected. They get lots of mosquito bites in Africa.

We don't have any case of people outside the high-risk groups getting infected by casual contact. Just think: if the disease were transmitted that way, we would have a whole different series of numbers from a city like San Francisco.

If the disease were transmitted by gay waiters, for example, everybody who had ever eaten in a restaurant in San Francisco would be infected. As it turns out, nobody has been infected that way. It is predominantly a sexually borne disease, and it is a sexually transmitted disease in this country.

I am not worried about the mutation to other transmittable forms. It's technically and actually a very difficult virus to get. It is relatively easy to kill, and it is difficult to transmit. The American public does not need to panic. We have to get the education out there so people can understand those things.

MR. RUDIN: Is there a possibility that it would help people to understand if we started referring to it directly as venereal disease?

DR. GLEESON: I suppose it wouldn't hurt. I think more and more it is being referred to as a sexually transmitted disease.

MR. MICHAEL CAVANAUGH: One of the underwriting tools that we use in the application is the question, "Have you smoked a single cigarette in the past year?" We also ask, "Have you ever used marijuana, drugs, etc.?" I recently received an opinion that this question is not very much in use because we would have to prove a persistent pattern of use of cigarettes or of drugs. I wonder whether anybody has had any experience with trying to rescind a policy or deny a claim on the basis of a question like that.

MR. SNORE: We don't use exactly that question. We use a question that says something along the lines of, "Have you smoked cigarettes within the last twelve months?" Then we ask some additional questions about other forms of tobacco use. We have not had occasion as yet to actually rescind a claim based on inaccurate answers to those questions. We are looking hard for a good case in which to take that action, because we think it is important to try to get some precedent on misrepresentation in answers to smoking questions.

MR. MINCK: Mr. Dederer, you agree with that, I take it?

MR. DEDERER: Yes.