RECORD OF SOCIETY OF ACTUARIES
1990 VOL. 16 NO. 2

AIDS -- THE REINSURER'S VIEW

Moderator: ROBERT J. TIESSEN
Panelists: KENT H. NICKERSON
JOHN S. TILLOTSON
Recorder: ROBERT J. TIESSEN

- o What are the reinsurer's results?
- o How do reinsurers respond to the AIDS threat in terms of extra reserves, tighter underwriting, etc.?
- o Can reinsurers set the market?

MR. ROBERT J. TIESSEN: Our speakers are Kent Nickerson of Sun Life Assurance of Canada, John Tillotson of Transamerica and me. AIDS is a problem of the life insurance industry that only came to prominence a few years ago. Newspaper stories on AIDS are common, other items in the insurance press are quite frequent, and there are voluminous reports put out by various actuarial organizations. This diversity of material is matched only by the diversity of opinions on what should be done about AIDS and also the gap between what should be done about AIDS and what is actually being done about AIDS. AIDS is a mortality issue. Many insurance companies have mortality as only a small component of their total business, with investment being the larger piece. Reinsurers, however, are predominantly mortality risk carriers. Therefore, they might be at the leading edge of development. What are the recent developments in the AIDS field? Kent Nickerson will speak on externally visible developments, John Tillotson on internal developments and I will finish with a discussion of the reinsurer's place in the market.

Our first speaker is Kent Nickerson. Kent is the reinsurance actuary for the Sun Life Assurance Company of Canada. Kent has 12 years experience in the industry, the last eight in the product development and reinsurance field. He is currently responsible for reinsurance pricing, valuation and financial modeling.

MR. KENT H. NICKERSON: I will look at visible responses of the reinsurance market towards AIDS. The first one I want to talk about, which is probably the most significant, and in some circles maybe the only response, has been that of the underwriting front, with respect to blood testing for the AIDS virus. I've looked through our underwriting files and notes on our meetings with various reinsurers, and the earliest mention of blood testing was a comment by someone from the reinsurance division of a company that writes both reinsurance and direct business. It was from April 1986. While the direct side was testing at $500,000, the reinsurance division was not then pressing for any testing by clients. In July 1986, we note that there was one reinsurer testing at $1.5 million. A comment from another reinsurer was that they think some of their clients, perhaps a lot of their clients, are testing, but they're not insisting on it, and not really worrying about it. When I think about these high limits from today's standards, it seems extremely liberal, but we have to remember that four years ago, this was considered fairly normal and appropriate at the time. As we look along a little farther, we see that

during the first half of 1987, most reinsurers were testing at a $500,000 limit; high by today's standards, but as I reviewed our notes, I noticed that when some moved to $500,000, it was considered a bold step at the time.

Also during 1987 we had a wide range of differences among reinsurers. My notes indicate that during the same month in 1987, we had one reinsurer considering a reduction of their limit to $200,000, while another with no limit was debating the issue. They felt they should be doing something, but they weren't sure exactly what that should be. Things started to move a bit more quickly, and in the second half of 1987 we found most reinsurers insisting on testing at $200,000-250,000 and by the first half of 1988, we saw most of them down to the $100,000 level. I guess this is where you'd say that the reinsurers had pushed the testing limit down below the ceding companies retentions. So all of their business was being tested except for perhaps quota share. That was as far as it was going to go. Looking at the timing, it certainly appeared easier to lower existing limits than to introduce a testing limit. Over the same time period, I remember that we had numerous discussions; perhaps the most common thing that reinsurers have done about the AIDS question is to talk a lot about it.

Talking with underwriters at other companies and my own company, I was faced with a comment -- that the underwriting community has reacted quickly and decisively with increased requirements, while we, the actuaries, were dragging our feet with respect to pricing action required to take into account the additional cost of AIDS claims. I had to admit that compared to what we had been doing on the pricing front, they were more or less right. However, I look back at the notes and I realize that it took about two to two and a half years for these limits to move and for the quick and decisive action to be taken. So I leave it to you to decide whether two and a half years is quick and decisive enough. However, it seemed at the time that things were moving quickly, and I think it is interesting today to look back and view it from a different perspective.

Another action that I think reinsurers have taken is with respect to product design and actions to reduce the antiselective potential in certain types of business. This is a visible response in the same way that testing limits were, because such changes are announced to the public. I am not aware of any reinsurers going out and saying they are not going to support that type of product or that feature, guaranteed insurability or whatever. However, I think there are a number of actions taken in this regard. I think an important product feature with antiselective potential is the guaranteed insurability option. We stopped offering reinsurance support for GIB in 1987, and one of the riders we found particularly troublesome was a so-called "beneficiary purchase split survivor purchase option" where the beneficiary could purchase an amount of coverage after the original insured had died. Part of the problem was that the amount of the option was often 10 times the original face amount. Recently I've seen requests for reinsurance of this type of product dry up, and I'm not sure whether they've just gone elsewhere or whether the reinsurers have just stopped supporting that type of product.

Another very important topic is the topic of rate guarantees. In the U.S., I think many companies are fortunate that most term products are not guaranteed, and that's usually because of the deficiency reserve problem. I think it certainly would be ironic if some

companies were able to avoid very disastrous results because of a product feature they put in as a result of the dreaded deficiency reserve regulations.

I think we have to look at guarantees at two levels. Rate guarantees at the policyholder level and rate guarantees at the reinsurance level. It only makes sense to me if those two sets of guarantees are sympathetic and consistent. It was mentioned at this meeting that reinsurers and ceding companies should talk to each other about the rate guarantees and what type of joint action could be taken in the event that a rate change is considered necessary. I recently saw an instance where a ceding company was looking for reinsurance with coinsurance premiums based on the guaranteed rates, while they had other current rates on the market for policyholders. In effect, it was a thinly disguised attempt to get the reinsurer to guarantee the rates, and I believe there are instances where direct companies have rate guarantees and reinsurance rates are not guaranteed. I don't want to pick on either side here, but I think those are unfortunate circumstances; the rates have to move in tandem, and the two companies involved have to discuss this eventuality in advance. Many, many reinsurance rate guarantee clauses have the comment that rates are not guaranteed, but for technical reasons, relating to deficiency reserves, the reinsured does not anticipate increasing rates. I've talked to a number of reinsurers and I think that reinsurers would be hard-pressed to increase rates due to experience on that basis. In Canada we've had different valuation requirements, and as a result, most rates are fully guaranteed. There is one reinsurer in Canada who has changed their standard wording to include quite an extreme eventuality. They've changed their standard wording to say that if, in the event that the AIDS problem becomes so severe as to threaten the solvency of the industry and the government allows companies out of their policyholder guarantees and to increase rates, that this particular reinsurer will participate in those increases proportionately. If it comes to that, then we're all in big trouble, but it's interesting to note that they've considered that and put it into their wording. Both direct writers and reinsurers, all of us who have mortality risk, have to be concerned about the future potential, and I think it's a very large and unpredictable problem, and so therefore, we'll find solutions if we look together as partners and not as adversaries.

I'll make some general comments briefly about the level of AIDS claims. Mel Young found in his survey that 1989 AIDS claims by reinsurers were about 50% higher than they were in 1988. Our own experience in 1989 was about 3% of our claims for reinsurance and 2% for direct business. We looked at the industry results and there was about 1-2/3% in 1988 and about 1-2/3% for reinsurance and about 1-1/3% for direct business. These are not large numbers. I think from my experience in recent years, reinsurers have been profitable. And as a result, the reasoning often given is, "Well we have not been hit by too many AIDS claims, and therefore, we don't need to do much about it." If we look at the reaction in Canada to pricing for AIDS, during 1988 certain valuation requirements came out for the 1988 year end, and pricing was prompted by the fact that we had these requirements. But if we look at the timeframe again, the reserve requirements came out in the second half of 1988, and here we are approaching the first half of 1990. We still find that pricing for AIDS in Canada is perhaps drawing to a conclusion as most of the companies are moving their rates, but it's taken some time. We can infer on this limited basis if there is perhaps a two-year, two-and-a-half-year rule, then the reinsurance market takes that long to do anything. However, comparing the

market between Canada and the United States, we find a much smaller number of reinsurers, and I think on the whole, relatively speaking, a much more highly motivated market to change the pricing.

Another item I think worth mentioning in regard to pricing for AIDS is that if we look at the modeling that's been done in Canada, the United States and Britain, there is a common thread in the projections of AIDS results. You can have your own opinion of whether it should be high or low or somewhere in the middle, but one common thread is that there will be a peak in the AIDS mortality in the second half of the 1990s. And if we also accept the idea that it takes somewhere around a dozen or so years for HIV infection to end in death, and we price new business on the assumption that it's going to be tested, perhaps that indicates that most of the AIDS claims are already on the books. It's now too late to do much about the pricing of the inforce. So, my prediction on pricing for AIDS is whatever we've seen up to now is it; we're not going to see a whole lot more. Maybe Bob will have more to say on the pricing aspects.

MR. TIESSEN: John Tillotson will be our next speaker. John is the director of actuarial research for Transamerica Reinsurance. John worked as a pension consultant after getting his MBA and then switched to the individual life line. He has been with Transamerica for 15 years, the last five in his current position. John will describe the internal activities undertaken by Transamerica in response to the AIDS threat in their business.

MR. JOHN S. TILLOTSON: As Bob mentioned, I'm going to discuss several aspects of AIDS as it relates to our reinsurance operation at Transamerica Reinsurance. First, how do our underwriters evaluate clients with respect to AIDS? Second, what claims experience has been projected by our AIDS model? Third, what have we done with respect to reserves, surplus and mortality assumptions? Fourth, how does our AIDS model work? Fifth, why do our assumptions differ substantially from many of those we've seen in published reports? And finally, what are the danger signals we are looking for in our ongoing monitoring of the AIDS epidemic?

With respect to AIDS, our underwriters go through several steps in the evaluation of a potential reinsurance client. We make sure that their retention, nonmedical, and blood testing limits conform to our minimum guidelines. In general, we insist on blood testing at $100,000. We review the client's application questions on AIDS. We evaluate the markets they sell in for relative AIDS exposure. Most of this evaluation is geographical, such as urban versus rural, and high risk states versus low risk states. Finally, we discuss with them their actual underwriting and claims experience to date with respect to AIDS. Our underwriters also communicate closely with existing clients on matters related to AIDS. We carefully review each and every AIDS claim that occurs in our reinsurance in-force. An examination of the original underwriting can often lead to improvements which benefit both us and our clients.

Our normal underwriting audits also facilitate this process. During a recent audit, for example, we discovered an unusual number of policies with face amounts just below the $100,000 blood testing limit. Naturally we were concerned that this might represent severe antiselection by infected or high risk individuals. Fortunately, it turned out to be

an attempt by the selling agents to avoid the delay and bother of asking for a blood test. Nevertheless, we're keeping a close eye on the claims experience for this particular block of business.

In 1987, we set up a task force to estimate AIDS claims over the next 25 years for both our reinsurance operations and our direct life insurance operations combined. We projected that AIDS claims as a percentage of total claims would reach 7% by the mid-1990s and then gradually tail off. Our actual experience since 1970 has been moderately favorable compared with these projections. We now anticipate the maximum will be around 5% or 6% of total claims. We are currently running at about 3.5%. Based on the results of these calculations, we decided that it was not necessary to hold additional reserves or surplus to cover claims from AIDS. This decision is still in effect because of our favorable experience to date. We continue to monitor the situation closely, however. Any serious deterioration in our experience or in our expectations will cause us to recalculate our safety margins and reevaluate this decision. We also have adjusted our reinsurance mortality assumptions in the higher risk states to account for AIDS. The effect of these adjustments is to increase our overall mortality assumptions by about 2% on a weighted basis.

The following steps indicate the type of model we use to project our AIDS claims experience. We estimated the number of individuals infected with the HIV virus as of January 1, 1987. Then we estimated the number of new infections, year by year, for the subsequent 25 years. We then applied progression rates to get the number of AIDS deaths year by year over the same period. Next, we estimated how much life insurance coverage these people dying from AIDS would have with our direct side and with our reinsurance in force. Finally, we ratioed these company AIDS claims to our total projected company death claims, on a volume basis, for the same 25 year period. Two of the most difficult calculations in these projections are (1) estimating the number of current infections in the country, and (2) translating national figures into company figures. To obtain an estimate of current infections, we first decided to completely ignore the Centers for Disease Control (CDC) estimate of one to one-and-a-half million that was published in 1986. Instead, we developed what we call a "backwards" calculation, using the CDC reported deaths, assumed progression rates from Cowell & Hoskins, and an estimate of the degree of CDC underreporting. We ended up with a best guess of 400,000 infected individuals as of January 1, 1987. We currently believe that this figure was too low, because of the rapid spread of infections among drug users. Since drug users do not own a lot of life insurance, we believe that our original projections are still reasonably valid. We used two different methods to translate national figures into company figures. The first method involved estimating how much life insurance was owned by high risk individuals, relative to members of the general population. The primary difficulty here was the fact that the extent and effectiveness of antiselection efforts is very hard to get a handle on. To bypass this problem, our second method simply assumed the constant ratio over time, between the CDC reported deaths and the volume of AIDS claims reported by our company. Results of both methods were, fortunately, reasonably close together.

The often large differences between one actuary's AIDS projections and another actuary's AIDS projections usually are not the result of using different methods, but are

the result of using different underlying assumptions. We discovered this fact back in 1987 when an outside actuary estimated our AIDS claims would be seven times greater than our inside estimates indicated. We firmly believe, and the evidence to date strongly suggests, that this outside actuary and many others in the profession have been overly conservative in the development of AIDS projection assumptions. In particular, there are four areas in which we believe many actuaries tend to be too conservative. First, they overstate the insurance ownership of members of high risk groups, relative to the general population. Second, they overestimate the ability and motivation of high risk individuals to effectively antiselect. I'd like you to ask yourself, what you would do in the following situation. First, you do not have anyone financially dependent upon you. Second, you just found out that you have an illness that will result in your death in about 10 years. Third, you expect to pay substantial sums in medical bills during that 10 year period. And finally, you may be unable to work and earn an income during substantial portions of that 10 year period. So I'm asking, even if you could get life insurance at standard rates, without any difficulty, would you be willing to shell out money for premium payments when you have all these other financial concerns? The third way in which we believe many actuaries are too conservative is that their models assume identical behavior within the membership of each high risk group. And the fourth way is that many models assume no behavioral changes subsequent to learning the dangers of the various high risk activities.

Back in 1987, we were particularly interested in the last two points, regarding the behavior of high risk group members. We had seen several models which assumed identical behavior patterns within the estimated three million members of the homosexual risk group. Common sense, however, told us that this was very unrealistic. Instead we decided to use what might be called "the 80/15/5 rule." Think for a moment about all the adults you know and how much gambling they do. Perhaps 80% gamble occasionally or not at all. Another 15% gamble on a regular basis, but keep this behavior under control. And finally, the remaining 5% have a serious gambling problem. Please keep two things in mind here. First, the numbers 80/15/5 are somewhat arbitrary. And second, the range of behavior is a continuum with no clear-cut boundaries that really divide it into three succinct groups. Neither of these facts, however, detract significantly from the main point: this kind of behavior, gambling, is highly skewed. The same 80/15/5 rule can also be applied to many other forms of behavior. These might include alcohol use, sexual activity among teenagers, drug use and so forth. In other words, we view this rule as having a general applicability to most types of pleasurable activities. When we applied this thinking to our AIDS projection, we reached the following conclusion. The virus would spread very rapidly through the most promiscuous 150,000 or so homosexuals. Considerably less rapidly to the next 450,000 and very slowly through the remaining $2.4 million. Furthermore, this slowdown would occur even in the complete absence of awareness of the AIDS virus. It would simply be the result of normal skewness of activity among any group of people. We now add such awareness of the virus to the picture around 1983 or 1984 and ask what behavioral changes we should expect. The extreme 5% who would be unable or unwilling to change their behavior would probably already be infected. The next 15%, who by definition have reasonable control over their behavior, would either eliminate all risky behavior or at least reduce it significantly. It also seems probable that the remaining 80% would stop virtually all risky

behavior. This analysis led us to believe that there would be very few new infections in this risk group after the first half million or so were infected.

Now back in 1987 we didn't have any hard evidence to back up these conjectures. Yet the common sense was so compelling that we felt comfortable basing our entire AIDS strategy upon it. So far, at least the statistics and various studies we've seen have supported our conclusions. As I mentioned a while ago, our actual AIDS claims experience has been even better than our 1987 model predicted. We believe this is the result of being somewhat too conservative in our analysis of the antiselection that occurred during the mid-1980s, prior to the general tightening up of underwriting controls. We reviewed our AIDS claims one by one in 1987 and grouped them into two broad categories. What we call the "nonantiselection claims" have issue dates going back as far as 30 or 40 years. Their average size is only about $10,000. The growth of these claims has paralleled the growth of the AIDS deaths reported by the CDC, and we have every reason to believe that it will continue to do so. The other, "antiselection claims," were issued primarily during the mid-1980s, and their average size is about $150,000. In our 1987 projection we assumed that, at time of issue, these individuals were recently infected with the HIV virus. As such, we did not expect our claim experience from this group to hit its maximum until the mid-1990s, because it takes about 10 years, on the average, between infection and death. Our data is now indicating, however, that the claims from this group are already leveling off. This would be consistent with the theory that these individuals were further along in the AIDS progression at the time of issue than we originally believed. It could well be that the typical antiselection claim comes from an individual who, at issue, was already experiencing some serious symptoms. Such individuals would have reached the point where denial or doubt would no longer inhibit them from making a major life insurance purchase.

I believe it is a reasonable explanation of the results we are witnessing. Despite the favorable results we have experienced so far, we are not letting our guard down at Transamerica Reinsurance. We continue to monitor closely all of the articles and statistics that are published on AIDS. In particular, we are on the alert for any indication that there has been a major breakout of the virus in the heterosexual community in the United States. While the numbers of such heterosexual cases have been growing, they're still very small and appear to be largely confined to some inner city prostitutes and the sex partners of infected drug users. Nevertheless, the situation could change quickly. We are also watching for any evidence that the virus is mutated in such a way as to make the disease easier to spread. Finally, we are constantly reviewing applications and claims to identify any new patterns of antiselection. As I mentioned earlier, one aspect of this is to watch for unusual levels of sales just below the blood testing limits.

In summary, we feel that we have been more than sufficiently prudent in our response to the AIDS epidemic. Our experience has been favorable so far, and we believe it will continue to be as long as we don't let our guard down.

MR. TIESSEN: I graduated from the University of Waterloo in 1974 and joined the marketing actuarial department of the Mercantile & General Reinsurance Company. After working in various positions in the department, I am now the Actuarial Vice President in charge of individual U.S. products.

The topic I'm speaking on was listed in the original program as, "Can reinsurers set the market?" Kent and John have stated what their companies have done in various aspects of the fight against AIDS. You have not heard them discuss pricing much. I'm not going to discuss pricing either, although the question of the reinsurer's role in the market is often thought of in terms of pricing. Reinsurers have been quite concerned about the mortality risk as a result of the advent of AIDS. When the news about AIDS came out, reinsurers were among the first to advocate tougher underwriting rules. Did they lead the market in this area? Somewhat perhaps. Perhaps, more accurately, reinsurers made it easy for any one direct company not to lead the market. Our underwriters found that the thing that most companies asked us about was where their own underwriting limits stacked up against the competition. The main reason for this was that they did not want their underwriting limits to be significantly different from what their competitors were doing because of the disadvantages that this might create. Therefore, they used reinsurers to be at the right relative position, as far as the market was, in the area of testing limits. Companies changed their testing limits as a result of information that they received from reinsurers and as a result of where the general market was with regard to testing limits. In addition, since most of the reinsurers would not accept risks that were not HIV blood tested above $100,000 after certain dates, this $100,000 limit was eventually used by most companies for their own testing limits.

However, we all know some companies that are still not testing at $100,000. After all, you need not test on anything you're willing to retain yourself, as far as most reinsurers are concerned. This market truth about the reinsurers not being able to lead the market is confirmed by HIV urine testing. Most reinsurers are not promoting the use of this test, but many companies are utilizing it for amounts at the low end of their own testing range.

Have reinsurers led the HIV-AIDS market in some other jurisdictions outside the United States? In the U.K., the Committee of the Institute of Actuaries working with the regulatory authorities agreed on required reserve adjustments as a result of AIDS. This was in spite of the fact that detailed questionnaires had been developed to specifically zero in on the AIDS risk. Some companies in the U.K. also developed AIDS exclusion policies. However, the extra reserve that was required as a result of the work of Institute of Actuaries was quite high and most U.K. companies put through sizeable rate increases for their nonpar business once the AIDS reserve level was finalized. Did the reinsurers set this market? Not really. The reserve basis in the U.K. is more in line with GAAP reserves, and so extra reserves for large unexpected claims from AIDS were a major concern. When the reserve increases were mandated by the government, price increases soon followed. This seems reasonable, but when you remember that AIDS in the U.K. population is running at about one-tenth of the U.S. level, and single males are often asked on the application if they engage in homosexual activity, the action in the U.K. appears excessive in comparison with what is happening in the U.S. As nonpar term reinsurance is not a major proponent of the U.K. market, competitive pressure does not seem to be a factor in price increases there.

In Canada, AIDS reserves have been required since 1988. There have been premium adjustments as well. Since the government introduced the new tax on the inside cash value buildup at roughly the same time, it is difficult to point to permanent products and

say there have been specific increases for AIDS. Most of the smaller Canadian companies have increased term premiums for AIDS costs. They rely on reinsurers to a large extent and sell mainly term products. It is estimated that current increases are not adequate to cover projected costs, however.

Did reinsurers have a role in the move of the Canadian marketplace? Some reinsurers did raise their rates, but not in any kind of coordinated, consistent manner. The market reaction to sizeable rate increases can be easily imagined, especially when many of the larger, mainly permanent companies, have not yet increased their term rates. The term market in Canada is apparently quite fluid; some companies are rolling back previous rate increases.

What is the reinsurer role in the U.S. market? While there are many reinsurers active, the top five have about two-thirds of the new business volume based on preliminary figures published in the latest *Reinsurance Section Newsletter.* Can the competitive market that exists in the U.S. allow any company or any reinsurer to set the market? This seems unlikely, given the current state of the U.S. marketplace. A quick check to see if leadership is present in the interest rate field would quickly confirm this. What then is the reinsurer's role? Reinsurers try to disseminate information and help their clients survive and prosper. This is what they did with respect to testing limits. Since testing limits are not as prominent or as hard to change as premium rates, direct companies have been more reluctant to change premium rates. Is this reluctance justified? My reading of the situation is that no company has increased rates by the magnitude suggested in the major studies that have been published so far. And only a handful have set up specific extra reserves. Information on this area was developed by Milliman & Robertson who did a survey for the Society. They surveyed approximately 150 companies. Twenty-one of 51 mutual companies surveyed said that they are incorporating AIDS in their pricing and five have set up extra reserves for allocated surplus. For stock companies, 35 of 95 companies say they are pricing for AIDS and eight have set aside additional funds. I haven't seen any significant pricing in the plans that have crossed my desk lately. The study did not indicate what the extent of the AIDS pricing of these 56 companies was or whether they had made changes in other items of their pricing at the same time that they had incorporated AIDS into their pricing calculations. John described the extensive work done by Transamerica in deciding on their course of action with respect to AIDS. I believe he indicated that another actuary had reached a significantly different conclusion on the impact that AIDS might have. It's not surprising that two actuaries have reached different conclusions in an area as subjective as AIDS still is. My own company has established substantial AIDS reserves in addition to our usual 80 CSO reserves. It might be more accurate to say that we have allocated surplus, given the current unfavorable tax treatment of AIDS reserves. The figure of our additional reserves is about 29% of our regular U.S. reserves. This was established after comparing the expected value of future AIDS claims against the existing margins we felt to be present in the valuation table.

The Actuarial Standards Board (ASB) is resubmitting its draft proposal on the treatment of additional costs for AIDS. I believe Harold Ingraham said that a final position is expected to be ready by September 1990. During the discussions of this draft paper, reinsurers were not mentioned as a driving force in the area, and I think this wasn't a big

surprise. What about pricing for AIDS? Will AIDS claims change the cost structure of life insurance? I checked for the latest A. M. Best report on AIDS claims. They're only available for 1988 so far. But they indicated that, for the life insurance industry as a whole, life AIDS claims were 2% of the total, and this was up from 1.4% in 1987. I believe the indication is that claims for 1989 are 40-50% higher than for 1988. The increase in the AIDS claim rate seems to be following the initial Coxwell & Hoskins curve, which starts out at fairly modest levels, but increases to fairly high levels later on in the course of the epidemic. From my own company, AIDS claims were running at 3.8% of total claims for U.S. business in 1989, and 0.2% for our Canadian business. Are these figures cause for concern, or more bluntly, are they cause for changing our cost assumptions? Since company risk characteristics are all different, you'll have to apply the techniques that have been outlined earlier in the session to decide what is the proper course of action for your own company. Do not expect the reinsurers to set the market, however. For this to happen, not only would all reinsurers have to have the same opinion on what the market should be, but they also would have to implement their opinions simultaneously across a broad range of varied situations. Besides a substantial practical problem involved in this, you would also have to assume that there were no outside restrictions.

The Canadian market might give us some idea of what's happening here. When we went to some of our Canadian clients and asked them what they might be able to do with regard to changing their prices because of AIDS, the time frame for putting through premium rate increases for some companies was very long -- three to six months or even longer. Trying to get a common industry response in this situation is quite difficult, especially when people are worried about being out of line with the rest of the industry. The situation in the United States, where there are many more companies, can easily be imagined as being much more difficult to get any kind of consistent response put through. I believe the reinsurer's role in the current AIDS environment will be the same as it was in the past -- a role of information exchange. Information exchange on underwriting practices, on product design, on reserves, and on prices. The reinsurers may know where the industry is heading, but they cannot lead it.

MR. MELVILLE J. YOUNG: I don't have final numbers from our AIDS claims survey, because we're still four companies short and we haven't put together the Canadian data yet. But we thought it would be interesting for you to hear some of the results that we have. We've been putting together this database, which includes all companies that do reinsurance of some type in North America, for the last five years. The first cell is individual ordinary reinsurance -- U.S. It's the most significant cell. But we also have a large cell that's the same company (some of those same companies give us their primary experience as well). On the individual ordinary reinsurance -- U.S., as a percentage of claims by amount, the percentage in 1987 is 1.36% and in 1988, 1.64%. So that was about a 20% increase. In 1989, its 2.41%. By number, in 1987, 1.39%; 1988, 1.84%, and 1989, 2.63%. John mentioned that there might be some leveling that some companies have noticed in a particular year. What we've noticed during the five years is there are companies that generally will have one or two bad years, so if you've had a good year in 1989, it doesn't mean necessarily that it's leveling. It's just that you don't get hit with these things every year.

Early indications from my conversations with people are that 1990 is starting out to be much worse than 1989 started out. If you're curious, I've added the three companies that have not yet reported in. I've added their 1988 numbers to 1989 just to see what the absolute numbers would be. Again, for the same category, individual ordinary reinsurance, the total AIDS claims in 1988 were $22 million (this is gross before retro), and all causes, $1,343 million. In 1989, the AIDS claims would be roughly $33 million -- just about 50% higher. And the total claims were about $1,480 million which is about 10% higher. The 10% may not mean anything. It might be that's what the expected would have been. But definitely AIDS claims are up.

There was a major claim that we excluded from the study and footnoted in the report. We probably will do the same thing this year another big claim.

MR. TIESSEN: That would be a 1990 claim?

MR. YOUNG: The last I heard it was somewhere in the $20-30 million range.

MR. TIESSEN: Okay, so would you plan on excluding it on the same basis?

MR. YOUNG: I was planning on footnoting it, just as I had done before.

MR. TIESSEN: You are talking about $50 million in claims that is excluded from your general numbers then.

MR. YOUNG: In the particular years, yes. The individual ordinary primary company experience is showing similar deterioration. We are still missing some numbers, but the results there show similar deterioration.

MR. DENIS W. LORING: Just a comment on Mel's data. If we're going to exclude some cases, just because they were big claims, then when you're trying to evaluate the impact of AIDS on your business, you really should be excluding all the premiums that relate to claims of such size; you would exclude them if they were AIDS claims. So, the actual effect of AIDS, in that sense, is going to be larger than numbers that would simply exclude some big claims, without excluding the relevant premiums. Whether we exclude them or not in the study, that's still $60-70 million of AIDS claims that were paid. I don't think we want to lose sight of that.

MR. YOUNG: The reason we excluded them in the footnote is we were trying to show the trend in claims.

MR. JOSEPH F. KOLODNEY*: When you were talking about your statistics of 3.8%, that was by amount. What about by number of policies?

MR. YOUNG: As a percentage by amount, Mercantile & General was 2.9% in 1988 and 3.8% in 1989. By number of policies it was 1.8% in 1988 and 3% in 1989.

* Mr. Kolodney, not a member of the sponsoring organizations, is Senior Vice President of Thomas A. Greene & Company, Inc. in New York, New York.

MR. TIESSEN: So the figures by amount are somewhat higher than the figures by number.

MR. KOLODNEY: Now when you saw those results, did you do some analysis as to where it's coming from? Which companies they are and what their retentions are? What geographical locations and type of distribution system they use? Are these factors you're looking at?

MR. TIESSEN: Those are all factors we're looking at. We haven't been able to break down the results that closely. I think still a lot of the results turn out to be anecdotal. I know we had a large claim recently where someone with no immediate financial dependents took out a large policy in 1984 and died quite recently of AIDS and had their mother as the beneficiary. It was taken out before blood testing was done. We think with the current testing, we wouldn't be getting those kinds of cases anymore. But, dividing out the results by distribution system or things like that, I don't think our base is quite large enough to make those fine distinctions yet.

MR. KOLODNEY: So with blood testing levels down from the reinsurance point of view to $100,000 on a general basis, you're more optimistic about the future mortality as respects new business written say, from 1987-1988 going forward?

MR. TIESSEN: I think the experience of blood tested business will be better than experience of business that was not blood tested. But as I tell our underwriters, I don't think getting a blood test immunizes people from getting AIDS in the future. So, I don't think we can assume that there will be no claims from people that are blood tested now.

MR. KOLODNEY: But you're probably selecting out the most indiscriminate ones.

MR. TIESSEN: Yes, I would expect lower results from people who are blood tested.

MR. WILLIAM E. BUTLER: I wonder if anybody has had any ill results from AIDS on group life? This has been a big source of claims in our company and I'd be interested to hear what other people would say.

MR. TIESSEN: We do have AIDS claims in our group business. I think the concern on the group side is not quite as large as on the individual side, mainly because you can change the premium rates on inforce business; and if you can track the experience and keep your premiums adjusted, the poor mortality experience as a result of the additional AIDS claims is not nearly as serious on the group line as it is on the individual line. The group side is accustomed to having premium rate changes put through, so the problem in adequately pricing group business for AIDS is not nearly as great as it is on the individual side.

MR. KIN K. GEE: Have any members of the panel seen an increase in use or trend towards dried blood spot testing?

MR. TIESSEN: There has been more use of dried blood spot (DBS) testing at some of the lower limits. I know especially, some people have started using it for amounts below

$100,000, if they want to get below $100,000. I think the advantages of the dried blood spot over say, the urine HIV test, is that you get a lot of the side benefits of the blood test from the DBS that you don't get with the urine, cholesterol readings for example. People are looking at dried blood spots mainly on a cost basis, to see how their testing costs relate. Possibly, in situations where they are still using a nonmedical, they might get a dried blood spot if they're not getting a full medical exam.

MS. PATRICIA L. SHAPIRO: It would seem like a very large percentage of the AIDS claims in the first two years would involve misrepresentation. Does anybody have a guess as to what percent are contested and are all your numbers net of contested claims?

MR. YOUNG: Figures are net. Do you have a feel for what percent are contested?

MR. LORING: Our experience has shown for the first quarter of 1990, about 25% of the claims are contestable. That's much higher than it was in the past few years. In Equitable's direct experience, we're starting to see a move away from the noncontestables, except for what John calls the 80% group of small amount policies issued in the 1950s, 1960s, and 1970s, where there clearly was no antiselection, and into more and more claims coming from issues of 1985, 1986, and now getting into contestable issues. My guess is that we're going to see a peak of that, and then another decline away from the contestables as you get into the cohorts where a lot of people that would be contestable have been screened out by blood and urine testing. What you're going to have is that block that runs, let's say, from 1983-87. That's going to be your big claim group, which will now move into the noncontestable group.

MR. TIESSEN: Dennis, in your figure of 25% contestable, was that AIDS claims being contestable?

MR. LORING: That was roughly 25% of our AIDS claims were contestable, by amount.

MR. YOUNG: I'd like to mention one other curious fact that seems to come up in the survey. The average size claim, AIDS claim and claim by all causes, for reinsurers is virtually identical. In 1987 it was $43,000 AIDS; $44,000 all causes. In 1988, $38,000 versus $42,000; 1989, $32,000 versus $35,000. On the other hand, for direct claims, the average for AIDS in 1986 was $55,000 versus $9,000 for all causes; 1987 $48,000 versus $7,000; in 1988, $39,000 versus $9,000 and in 1989, $39,000 AIDS versus $8,000 all causes. If we were looking for causes of that difference, one reason could be that perhaps we don't try as hard on very small claims or claims below a certain size to identify a true cause of death. I don't know, maybe you could come up with some other reasons, but there must be some reasons there. The other thing that seems obvious to me in looking at the 1989 results, and especially taking into account the additional comment that Dennis made about ignoring the big claims, is it doesn't mean we're not paying the money. Eventually we're going to have to start recognizing these results that we've been shy to recognize before.