

UNDERWRITING AND RELATED MATTERS

- A. What basic principles should be observed in the selection of risks? What are the principal factors that affect the underwriting experience?
- B. To what extent has substandard underwriting been developed? What means are employed to assess the cost of the insurance equitably?
- C. How are sales policies and claim administration practices related to underwriting? To what extent is renewal underwriting employed?

MR. H. R. LAWSON, introducing section A, stated that the first and most obvious "basic principle" to be observed in the selection of risks for health and accident insurance is that there must exist a potential loss to be insured against. Loss-of-time insurance, so-called, is insurance against loss of wages. If the person applying for insurance is dependent, or indigent, or retired, or for some other reason not working for a living, there is nothing to be insured against. To use a common expression, there is no insurable interest. In the case of hospital and medical expense insurance, the person who would be responsible for paying the bills—usually the head of the family—has an insurable interest, whether he is a wage earner or not; but, if for some reason the necessary services would be available for nothing or would be paid for by somebody else, there would be no reason for the insurance.

The second "basic principle," in fact the only other principle that need be so characterized, is that the amount of insurance must not exceed the potential loss to be insured against. One could go further and say that the amount of insurance should normally be less than the potential loss, in other words that there should be some degree of coinsurance. In the case of loss-of-time insurance, the weekly or monthly benefit provided by the insurance policy should not exceed the insured's wages after taxes but should preferably be less; in the case of hospital and medical expense insurance, the benefits provided by the policy should in no event exceed the expenses that might be incurred, lest the insured be in a position to profit by his apparent misfortune.

This latter principle, Mr. Lawson said, is much easier to state than it is to interpret and apply. On the one hand it is possible in certain minor respects to be more liberal than purely theoretical considerations would indicate. On the other hand, and far more important, is the fact that the liberal interpretation of the principle mentioned, without the exercise of reasonable foresight and common sense, would inevitably result in serious losses. We know, for example, that a man earning \$25,000 a year cannot be insured for that amount or even for half that amount, because, by the

time disability strikes, his earnings might have drastically declined, or other circumstances might have arisen to make a modest free and taxless income seem attractive to him. All this is not mere conjecture but one of the inescapable lessons that sad experience has impressed upon us.

Passing now briefly to the principal underwriting factors that must be observed, he said that we recognize to a greater or less degree all those that apply to life insurance risks; physical condition and history, family history, occupation, habitat, environment, financial condition, and the like. However, the most important factor of all is the character of the person to be insured. Is he honest and industrious—a solvent, self-supporting and responsible member of the community? Or is he dishonest, shifty, a poor credit risk, indolent or in an insecure or seasonal occupation, living in an unfavorable environment or having a poor reputation? Sickness is not a clearly recognizable condition like death; and unemployment, laziness, the temptation of easy money, and outright fraud, all have a pronounced effect on the claim experience. A person dying of cancer, while by no means insurable, may still be a better risk for accident and sickness insurance than a person of poor character. By the same token, the character of the agent is also of the greatest importance, since the risks presented will to a great extent be but reflections of the agent who solicits them.

Referring back briefly to the other factors mentioned, he said it should be emphasized that some of them assume greater importance in the case of health and accident insurance than in the case of life insurance. For example, morbidity rates are very sensitive to occupation—not so much, apparently, because of the accident hazard as because of the social and economic factors involved. To cite another example, skin diseases and chronic respiratory conditions do not usually have an adverse effect on mortality but they do result in loss of time from work and in medical expense. Ailments of this kind call for special treatment in the underwriting of health and accident insurance.

MR. R. F. KILLION, introducing section B, stated that substandard applicants for individual health and accident insurance have been offered coverage under policies containing exclusion riders or general restrictions and occasionally under policies at extra premiums.

Exclusion riders, sometimes called waivers, have seen the widest use in the treatment of substandard applicants. Under this method, losses due to existing impairments are excluded from the coverage. To illustrate, an exclusion rider might read somewhat as follows:

This policy is issued by the Company and accepted by the insured subject to the understanding that this insurance shall not cover loss caused or contributed to by hernia of any kind.

It is customary to obtain the signature of the applicant indicating his acceptance of the limitation. These riders are used in connection with such impairments as unstable knees, chronic low back pain and impairments of sight or hearing. It is desirable to use an exclusion rider only under circumstances which will result in a minimum limitation of coverage to the insured. Extensive exclusions are generally impractical.

The wording of an exclusion rider must be drafted carefully to properly protect the company. It is not unusual for the same cause of loss to be described in different medical terms. For example, the terms bursitis, arthritis, and neuritis may be interchanged for the convenience of a claimant. If the policy excludes injuries to the lumbo-sacral spine, you may be presented with a claim for sciatica. The wording of the exclusion must anticipate these possibilities.

The use of exclusion riders, he said, is not entirely satisfactory. While it does permit issuance of insurance to an applicant who otherwise might not be able to obtain any, he has a policy which will not cover the loss most likely to occur.

Restricted policies are sometimes used for substandard applicants. One type of restriction is the elimination period or waiting period under which benefits are not paid for an initial period of disability which may vary from one week to six months according to the policy provisions. A policy with a substantial elimination period may be issued to an applicant subject to recurrent short periods of disability, such as are met in certain of the upper respiratory impairments.

The use of exclusion riders is not a solution to the problem of substandard underwriting. It is a method of avoiding the problem of substandard underwriting. A solution should provide a method for issuing coverage at the appropriate premium without an exclusion. The use of extra premiums to offer full coverage to a person having an existing or potential physical impairment has seen limited use, but it is being experimented with by some companies.

Obviously, Mr. Killion said, there are many difficulties to be met in developing such an approach under personal health and accident insurance. In the first place, there is no existing experience to indicate expected morbidity according to the various types of physical impairments. Also, it is suspected that company underwriting practice varies so widely that there would be a complete lack of homogeneous intercompany material for analysis. Then, since so much of the business is written nonmedically, it would be difficult, if not impossible, to properly identify cases for study. There are important inherent difficulties because of the nature of the coverage. Is it possible, for example, to issue full coverage at any price to a person already having objective symptoms of an acknowledged physical impair-

ment? As a claimant, this person would have considerable control over both the frequency and duration of disability.

In introducing section C, Mr. Killion stated that the underwriting of health and accident insurance should be done on the application and not on a claim statement. In this respect it is important to realize the claim frequency of health and accident insurance as contrasted with life insurance. Out of a thousand health and accident policyholders there might be, depending upon the type of coverage, as many as 300 claims in a year. In life insurance from the same group only five to eight claims would be expected. As a result of this claim frequency, the writing agent will be in frequent contact with his policyholder on a claim problem. Under the circumstances, it is essential that the original underwriting be done thoroughly in order that a claim will not be questioned on account of some matter which should have been developed when the application was being considered. Agents must be trained to realize the importance of transmitting all information to the home office. If the agents accept this responsibility, there are subsidiary advantages. It will be possible to reduce the number of medical examinations and also the number of mercantile investigations, both of which are important items of expense. By tradition, health and accident insurance is written nonmedically, although the trend is to ask for more and more medical examinations prior to issue.

An element to influence underwriting practice has been introduced with the New Uniform Individual Accident and Sickness Policy Provisions Law. Under this law, for the first time, individual health and accident policies must include a provision comparable to the incontestable clause of life insurance policies. This provision limits, to a period of three years following the issue of the policy, the company's right to void a policy on account of material misrepresentation, or to deny a claim because of the prior origin of an infirmity. While this provision has not been in use long enough to influence company practice to any great degree, it is fair to assume that its effect will be toward more careful underwriting before issue.

Under the great majority of policies in the personal health and accident field the company reserves the right to refuse renewal. The practice can be understood by consideration of some of the unusual features of this business. It is an insurance field in which the claimant can substantially affect loss frequency and even the extent of the loss. The degree of insurance hazard varies widely for economic reasons that are unpredictable. Without the right to refuse renewal, a company is subject to substantial losses from chronic or fraudulent claimants and has no way to correct an inadequacy of premium rates which may result from unforeseen contingencies. By reserving the right to refuse renewal, most companies feel that they can insure more people for greater coverage at less cost.

The current trend is toward limited use of this right by the companies. In the Metropolitan, Mr. Killion said, the annual rate of nonrenewal is less than two-tenths of one percent of the policies in force. However, this low rate of nonrenewal does not indicate the absence of need for retaining the right to refuse renewal. The existence of the right to refuse renewal undoubtedly acts as a deterrent in some cases. Companies having a proper appreciation of good policyholder relations refuse renewal only in extreme cases where that course of action is clearly justified.

MR. J. F. RYAN, in discussing section A, noted that while the factors that affect the underwriting experience are essentially the same as for life insurance, it is necessary to observe also their effect upon the insured's ability and willingness to follow the duties of his occupation, rather than their effect on longevity. Some impairments, of minor importance so far as life insurance is concerned, may preclude the issuance of loss-of-time benefits because of the possibility of a protracted period of disability. Similarly, moral hazard and overinsurance are of increased importance under health and accident insurance and are probably the most important of all factors. Agents who formerly sold only life insurance must be trained to underwrite health and accident business carefully, particularly in a company which has written substandard life insurance on a broad basis and has encouraged its agents to submit all risks and let the Home Office do the underwriting.

In discussing section B, Mr. Ryan said that the New York Life is following the usual practice of using waiver riders for most impaired risks, but is providing full accident insurance coverage at an extra premium to persons who are overweight, to those who have certain deformities, and to those who have had certain amputations. An analysis of their applications shows approximately 10% declined and 6.5% issued with riders. Of the declinations, 25% were for circulatory impairments, 10% for brain and nervous disorders, and 50% for other medical reasons. Approximately 5% of their accident policies and 10% of their sickness policies contain waiver riders; the percentages increase with age, and are lighter for males than for females. Almost 30% of the riders are with respect to eye, bone and joint disorders. By further experience and analyses they hope to reduce the number of riders and declinations, and to increase the number of cases with extra premiums.

Mr. Ryan said that increasing recognition must be given to the fact that accident and sickness claim rates vary by age and that premium rates probably should also vary by age or groups of ages. He suggested the possibility that the life companies might pool their individual health and accident experience through the Society of Actuaries, to develop suitable

statistics, encourage the development of substandard underwriting, and assist in equitable assessment of cost.

Under section C, Mr. Ryan stressed education of the agent, careful Home Office underwriting, and a "fair" claim policy, as essentials for good public relations. The New York Life has established a committee on "Field Underwriting Responsibility," which reviews applications on risks where the Home Office underwriters feel the agent did a poor job of selection, and recommends disciplinary action against the agent when necessary. With respect to renewal underwriting, no decision as to broad policy has been reached. Their renewal policy will be as liberal as experience permits where the policyholder's health has deteriorated after issue. To date, because of their recent entry into the health and accident business, only about twenty cases have been refused renewal, practically all involving misrepresentation at time of issue.

MR. E. M. MACRAE listed integrity both in the applicant and in the soliciting agent as the most important underwriting factor, followed by stability of applicant's income, and a reasonably liberal policy in settlement of claims. The policy referred to as "underwriting at time of claim" is one which, even if practiced in small degree, affects the whole industry adversely.

Discussing section B, he warned that antiselection will probably increase sharply when we grant health coverage to impaired risks. The Occidental Life does not issue coverage to physically impaired risks, but uses waivers when necessary.

MR. W. R. MULLENS said that the Business Men's Assurance Company has been issuing accident and health insurance on a substandard basis for several years. They entered this field primarily because they felt that there was a need for accident and health business on this basis. However, the volume of business submitted on a substandard basis has not been large. Their approach to the problem has been one of extreme caution and so far there has been no indication that the experience on this business has adversely affected their claim ratios as a whole, although the volume of this business is so small that it has not been found feasible to keep any separate statistics on the substandard alone. As a safeguard, issues on this basis are confined to ages below 60 and to contracts which provide a maximum of 12 months' coverage, granting or withholding in some cases the privilege of adding supplements such as hospitalization and surgery.

The underwriting of this type of business is approached with four possibilities in mind: the applicant may be rated up in class; an extra premium may be added; an Exclusion Supplement may be added to the policy;

or the applicant may be declined. The company feels that in those cases where it can be used the Exclusion Supplement is the preferable method of handling substandard business. In addition to adding an Exclusion Supplement, it is sometimes necessary to advance the class in order to provide for the increased accident hazard, for example due to the amputation of one leg or one arm. There are some cases where an Exclusion Supplement would remove so much of the insurance to the individual that he would have practically no insurance left. If it is determined that an Exclusion Supplement or an advance in class is not feasible, an attempt is made to underwrite the risk on the basis of extra premium depending upon the degree of the impairment. In general, they are guided by life underwriting practices and attempt to assess a numerical rating to the risk, that is, subject to 25% extra morbidity, etc. A numerical assessment of the risk having been determined, an amount which represents that extra percentage of the anticipated basic claim cost under the policy is added to the gross premium.

Mr. Mullens admitted that their underwriting of this type of business is to a large extent intuitive. They feel, however, that the advantage to their salesmen in being able to offer this coverage in certain cases outweighs the possibility of loss, particularly in view of the fact that no great volume of this business has been written.

Under section C, Mr. E. M. MACRAE noted that sales and underwriting departments are closely integrated in his company. Questionable claims are referred to a committee on which three of the six members are actively connected with underwriting policy. Their rules concerning renewal underwriting are as follows:

1. They review once a year the files on all risks which carry \$400.00 or more a month time loss benefits in their company or more than \$25,000 accidental death. Inspection reports on such risks are secured every three years.
2. Certain files involving amounts of monthly indemnity less than \$400.00 are also reviewed periodically in cases where the probable future earnings of the applicant did not appear to be very stable. The same rule is applied to certain other borderline risks.

MR. W. VAN B. HART pointed out that companies have learned to avoid overinsurance on weekly indemnity benefits, but have neglected to be careful on the newer types of benefit, permitting duplication of coverage with group casualty, Blue Cross, or individual policies issued by other companies. He suggested that there should be an attempt to remedy this situation.

PANEL MEMBERS, replying to Mr. Hart, agreed that this problem requires further study, inasmuch as there is at present no practical way of avoiding duplication.