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DIGEST OF DISCUSSION OF SUBJECTS OF SPECIAL INTEREST

INDIVIDUAL ORDINARY INSURANCE

Underwriting

A. What is meant by standard mortality in Ordinary insurance—*i.e.*, on what principles is the division between standard and substandard classes determined? How have mortality reductions of the past 25 years affected the concept of standard insurance?

B. What special problems, if any, must be considered in the writing of life insurance
   (1) at very advanced ages?
   (2) with mortality ratings in excess of 500%?

MR. PEARCE SHEPHERD, in discussing section A, stated that as a practical matter the standard class is and should be a broad one containing all lives with no blemishes and some lives with minor blemishes, that as an objective the standard class should meet the conflicting requirements of competition and agency satisfaction. The objective of a substandard offer is a price to secure the business without burdening the rest of the business.

The underwriter has demonstrated his ability to classify risks accurately into the "normal" and the various substandard classes, and with this ability in mind the following questions might be asked:

1. Can some mortality be ignored on large policies because of expense savings?
2. Can some occupational extra mortality be overlooked because of the expense of obtaining the information necessary to classify it properly?
3. Do the answers to these first two questions differ if the company is a stock company or a mutual company?

The facts are that certain appreciable aviation risks are being accepted in the standard class because of the high average size associated with such risks. It is difficult to find fault with this practical approach, since the objective is to give insurance at the most reasonable cost and cost includes expenses as well as claims. However, disturbing questions of discrimination remain and perhaps the rapidly spreading "pricing by size" approach to premium rates will cause a re-evaluation of this practice of informally pricing by size.

Mr. Shepherd believed that the broad approach to the underwriting of occupational hazards can be accepted without much trouble and

that there is a certain validity to the argument that some socialism is appropriate when applied to all but the most risky and dangerous of occupations.

Mr. Shepherd felt that, because of reduced standard mortality, the debits and credits of the numerical rating system no longer express the proper percentage deviations of certain impaired classes from the standard. Especially at younger ages the ratios of experienced mortality relative to standard are higher.

Mr. Shepherd noted that since it is probably reasonable to accept in the standard class groups of young lives showing extra deaths of 1.0 or 1.5 per thousand and groups of older lives showing 25% extra mortality, it means that groups are accepted as high as 300% of standard at the young ages grading down to 125% at the older ages. Temporary extra premiums, especially at the young ages, have some advantages in establishing a reasonable, economic basis for pricing many impairments.

MR. W. H. SCHMIDT stated that the concept of a standard class for life insurance is really more philosophical than scientific. "Scientific" statistical approaches to the problem of determining a standard range with respect to some impairments are quite correct statistically, but are completely inapplicable for setting underwriting policy. Perhaps there is no such thing as standard mortality since each company can set its own standard.

The underwriter has the problem of constructing a standard class from the class of people as a whole, of assessing in terms of dollars the extent to which an individual diverges from the "standard" and of compromising between a low mortality in the standard class and adverse field reaction. Mutual of New York decided several years ago that occupational extras of less than $2 per thousand should not be charged and that any additional occupational hazard up to $1 per thousand could be absorbed without significantly affecting the mortality in the standard class. Mr. Schmidt felt that similar criteria are equally applicable to medical impairments. Under this approach it is easy to see that the mortality reductions of the past 25 years and the resultant low basic mortality, particularly at the younger ages, have outmoded the concept that standard mortality can be limited by a numerical rating such as 125. Also, many impairments are less significant than they were and the standard class should probably contain more lives today than it would have two decades ago. Even though the technical difficulties of translating extra mortality into deaths per thousand are not solved, this should be used as the principal measure of underwriting success.

With respect to section B, Mr. Schmidt said that underwriters were

naturally suspicious of persons first needing insurance at advanced ages and that his company offered one plan for issue at ages over 70 only as a convenience for its field force. Mr. Schmidt did feel that there was a definite need for insurance to those with mortality ratings in excess of 500%, the problem being one of proper pricing, and that insurance companies should offer such insurance at least where there was no evidence of antiselection.

MR. D. J. VAN KEUREN, in discussing the first part of section B, stated there are many sound reasons for a company to extend its upper age limits for accepting risks; among them are: (1) the aging of the population with the consequence that past age limits are now less reasonable and (2) the desire of the field men to compete with those companies which are already offering insurance at these higher ages.

The primary underwriting problem, he stated, centers about the speculative antiselection at these ages, underscored by the high rate of premium when compared to the face amount of insurance. Except for certain business partnership insurance arrangements and estate tax situations, it is difficult to establish insurable interest much beyond terminal expenses. The underwriter must hold total insurance on a life to an amount commensurate with present economic value. With the onset of degenerative diseases the usual insurance examination is not very revealing and the odds favor that the insured will better appraise his remaining lifetime than the underwriter will. Cardiovascular-renal diseases, hypertension and overweight account for 80% of the declined cases and 70% of those issued substandard.

Another problem is that of dissatisfaction arising when the insured has paid more in total premiums than the face amount of insurance and the premium is large relative to the insured's income.

Another problem is that of a high rate of declined cases. When in 1955 the Metropolitan extended its upper age limit for insurance in the standard and first substandard classes, the field force was cautioned that the number of declined cases might be high. This was the case, but as the field became acquainted with the problems, the declination rate dropped.

The Metropolitan felt some concern over the possible high number of claims which might be rejected during the contestable period on issues to older lives, but their claim men feel that no serious problem of a high proportion of rejected claims on issues at older ages has arisen, perhaps because of the precautions taken.

The Metropolitan's limited mortality observations to date do not show unsatisfactory experience.

MR. R. R. GALLAGHER pointed out that the reason for insurance on applicants over age 65 must be acceptable to the underwriter. Valid reasons would include key man insurance and provision for inheritance taxes, but not, for example, burial expense insurance applied for by a son on his 70 year old father. A most important aspect in underwriting applicants at advanced ages is the psychological factor. For instance, a man with moderate physical impairment but with an intense desire to live would be a better risk than one in excellent physical health but without much incentive to live. In fact, he would consider an applicant 70 years old with blood pressure 170/100 whose build required a basic table debit of not more than plus 20 as being borderline standard if the psychological factor was favorable and there were no other complicating factors.

Concerning mortality ratings in excess of 500%, Mr. Gallagher stated that experimental underwriting using clinical statistics is necessary in the absence of insurance statistics in this area. The problem is for the clinician to pick out from a group of applicants, who on the average would be declined, individual cases that may be expected to have better than average experience. For instance, an applicant with a blood pressure of, say, 220/120 might be accepted at a very high rating if a reputable clinic reported that the vascular system showed comparatively little damage.

Mr. Gallagher expressed his belief that, as the mortality rating increased, so did the amount of shopping indulged in by the applicant, and that, therefore, it was very important that the premiums on highly impaired risks be paid for by a corporation or that the applicant be wealthy and desirous of the insurance for a good reason, such as inheritance taxes.

Because of the expense of the complete working up required for the careful underwriting of cases over 500%, North American Reassurance considers a case worth while only if it is for $25,000 or more. Their paid-for ratio of nearly 25% on such issues compares favorably with a rate of 40% on cases rated 250% to 500%. Their mortality experience since actively entering this field at the beginning of 1955 has been satisfactory.

Nonforfeiture Benefits

A. Is there a more satisfactory way of allowing for the expense of paid-up and extended insurance than the use of a margin in the rates of mortality?

B. Is there a more satisfactory way of defining the mortality basis of minimum extended insurance benefits than as a multiple of the mortality used in defining minimum cash values?

C. Is there any trend towards abandonment of extended insurance as a nonforfeiture benefit? Is the automatic premium loan provision a satisfactory substitute?

MR. J. S. HILL felt, with reference to section A, that a form of loading or option charge is not feasible because (*a*) nonforfeiture laws would require amendment, (*b*) there would be difficulty in drafting policy provisions and explaining to agents and policyholders, (*c*) the entire expense provision would be released when the nonforfeiture benefit became effective or a special reserve for future expenses would need to be established.

He pointed out that a margin of $\frac{1}{2}$ of 1% in the interest rate provides expense margins of 15¢ per $1,000 per year on the average on a policy going on extended insurance with a cash value of $60.00 per $1,000.

With reference to section B, he noted that Table 2 in Appendix C of the January 24, 1958 report of the Special Committee on Table X_{17} indicates consistently higher mortality on extended insurance when voluntarily selected by the insured, but stated that the committee's predictions of high extended insurance mortality where automatic premium loan is used extensively are not borne out by Minnesota Mutual experience where extended insurance mortality is not significantly different from that on other business of comparable age and duration.

Commenting on section C, he stated that Minnesota Mutual has achieved almost universal use of the automatic premium loan provision for 25 years by special design of the application, with little or no policyholder dissatisfaction. He preferred automatic premium loans to extended insurance because the insured (*a*) retains any supplementary benefits of the original policy and (*b*) has the right to resume premium payments without furnishing evidence of insurability. He commented on the extra administrative expense of automatic premium loans, but suggested this may be minimized in future by use of electronic computers.

MR. B. A. WINTER predicated his discussion of sections A and B on the assumption that (*a*) it continues to be desirable to include in policies at issue a guaranteed single premium basis for determining the amount of reduced paid-up insurance and the term of extended insurance, and (*b*) the basis chosen should give the maximum benefit to discontinuing policyholders compatible with no increase in cost to continuing policyholders.

He stated the basis must be chosen to provide for benefits such that the sum of

a) any excess of the expense of placing in effect the nonforfeiture insurance over the expense of effecting cash surrender in one sum, and

b) the present value, at the rate of interest actually earned by the

company while the nonforfeiture insurance is in effect, of death and endowment claims, surrenders, the continuing expense of administering the nonforfeiture insurance, and any dividends payable thereunder, should not exceed the cash surrender value that may be obtained instead at the inception of the nonforfeiture paid-up insurance.

He stated that review of recent studies by four companies contributing to the Society's Special Committee to Cooperate with the NAIC in the Construction of an Up-to-date Mortality Table (included in Appendix B of the January 24, 1958 report of that Committee), and the general considerations on the subject contained in the discussions before the NAIC that led up to the present standard nonforfeiture law, caused him to believe the 1941 CSO Table and the rate of interest used by the company to calculate its cash surrender values to be a satisfactory basis for determining reduced paid-up and extended insurance. Since cash surrender values computed by use of a more modern mortality table would not likely differ much from those computed using CSO, he thought it would be appropriate to preserve the 1941 CSO Table as the mortality basis for conversion of cash surrender values to reduced paid-up and extended insurance after adoption of a newer mortality table.

Alternatively, if the nonforfeiture laws are amended to prescribe a nonforfeiture mortality table with lower rates of mortality than CSO, he thought consistency would best be preserved by deduction from the cash surrender value of a stated amount per $1,000 insurance before applying the table to determine the reduced paid-up or extended insurance. The margin resulting from this deduction would be made available at the time needed, since most extra claims resulting from antiselection on extended insurance occur within a year or two after the option becomes operative, and most of the expense associated with either reduced paid-up or extended insurance occurs either at the time of conversion to such insurance or shortly thereafter when most reinstatements must be processed.

MR. J. E. HOSKINS suggested that concern over excessive periods of extended insurance may not be eliminated by making the automatic premium loan provision available. In 105 Travelers' cases changed to extended insurance during a recent 3-month period, 49 had not elected automatic premium loan though available, 7 had elected automatic premium loan but revoked in favor of extended insurance upon discontinuance of premiums, the remaining 49 had elected automatic premium loan which continued until the remaining equity, too small to pay a premium, was applied to extended insurance.

He felt this suggested the possibility that (*a*) a substantial proportion

of applicants do not elect automatic premium loan though available, (*b*) automatic premium loan included without election by the applicant is frequently revoked later in favor of extended insurance. In the case of (*b*), he suspected some antiselection. In some cases, coverage under extended insurance was both larger and for a longer period than it would have been under automatic premium loan.

MR. J. F. MACLEAN felt that, for a participating company, equity may be preserved within the current framework of the law, the CSO Table and competition, through judicious use of surrender dividends. (His company, Bankers of Nebraska, does not operate in New York state.) Such dividends, payable only upon surrender for cash, would represent (1) release of committed funds for possible loss on optional settlements from mortality and expense, (2) release of committed funds for possible mortality loss on extended insurance, (3) release of committed funds for predicted excess expense on reduced paid-up insurance, (4) savings in expense of establishing and maintaining extended or paid-up insurance. His company's scale is expressed as a graded percentage of the cash value with a maximum of ten percent in the twentieth and later years and a dollar maximum of $65 per $1,000 insurance.

He stated that under this system early years' dividends must be adjusted at the young ages to preserve equity between continuing policyholders and those who lapse.

He recommended that, when a new valuation mortality table is adopted, a new nonforfeiture table be derived by loading the valuation table *q* 30% plus one per thousand.

He stated that his company eliminated the automatic premium loan provision from its current series of policies after comparison of expenses of automatic premium loans with those of automatic extended insurance. Reinstatement without evidence of insurability is permitted within two years after default, if extended insurance has not expired.

MR. R. P. WALKER stated that, in determining a satisfactory expense allowance for extended term insurance, consideration should be given to the average size policy at the various ages. According to *Life Insurance Buying*, published by L.I.A.M.A., the average size adult policy purchased in 1956 was $7,500. The average size juvenile policy was $1,400. The average expense rate per $1,000 for handling extended insurance on the juvenile policies would therefore be over five times as great as for handling adult extended insurance.

MR. F. J. ALPERT felt the automatic premium loan is, in general, a satisfactory substitute for extended insurance, especially if its application is limited to inadvertent lapses. In New York Life, the automatic

premium loan provision has been available since 1944, on election only. Currently 99% of applicants elect the provision.

Automatic premium loans are not processed until 67 days after the due date of a premium in default. If repayment occurs meanwhile no interest is charged. He stated this procedure has been effective in reducing the number of new loans processed, with considerable expense avoided.

MR. J. R. GRAY said that at one time the extended insurance benefit may have been a satisfactory substitute for the automatic premium loan feature, but he felt that such is no longer the case. The present day policy contains many subsidiary benefits such as Disability, Double Indemnity, Family Income, Additional Term Rider, or the various benefits provided under a Family policy. The use of the extended insurance benefit markedly changes the insurance coverage provided by policies containing any such additional benefit and also necessitates the submission of evidence of insurability for reinstatement.

Miscellaneous

A. In what ways may life insurance contracts be redesigned to minimize a possible indefinite continuation of inflation?
B. In the computation of premiums, is there any more satisfactory method of allowing for lighter mortality among female lives than by the use of an age differential? Can the absence of differential rates for female lives be justified when premiums are graded by size?
C. To what extent have the respective theoretical disadvantages predicted for the "policy fee" and "size group" methods of grading premiums by size of policy been encountered in practice?

MR. R. H. GOEBEL, introducing section A, commented on minimizing the effect of inflation on the insurance company as opposed to such effects on the policyholder. He stated that as companies grow in size their unit administrative costs tend to decline, either because existing staff and machinery can handle the increased load or because more efficient procedures and machines can be put into use with increased volume. This he said might be called a built-in inflation hedge as long as volume increases.

Mr. Goebel stated that at the Northwestern National Life premiums on policies for $2,500 or more are a flat amount per $1,000 plus a charge of $9.00 per policy. However, below $2,500 the $9.00 charge would increase the premium beyond the range of acceptance. They therefore initiated a special line of policies referred to as their $1,000 series. This series was streamlined for ease of handling in the following ways:

1. Contracts are written only at ratings of 150% or less so that extended insurance is always the automatic nonforfeiture option with the reduced paid-up insurance option being removed because of handling costs.
2. The automatic premium loan provision included in their policies for $2,500 or more is excluded from the $1,000 series in order to avoid accounting costs out of proportion to the small sums involved.
3. Policy loans are granted but the loan interest rate is set at 6% in advance (comparable to a standard rate of 4.8%) to discourage loans and to help defray the costs of handling.
4. Optional modes of settlement are not permitted, simplifying policyholders' service work and lessening future costs.
5. Most of the contracts are nonparticipating to eliminate bookkeeping costs due to small total amounts of dividends.

Some difficulties were encountered with a few states concerning the $1,000 series and its special provisions. Mr. Goebel said they had not experienced a substantial upgrading in size by changing to graded premiums.

Concerning section B, Mr. Goebel stated his company felt that it was unwise for them to grade premiums by sex even though they graded by size. This was because their agency force does not sell much to the female professional and executive market, and the additional expense could not be justified.

MR. ARTHUR PEDOE presented some points in regard to section A. He suggested that the reversionary bonus system of allotting dividends, which was almost universal in England and Scotland, did minimize a possible indefinite continuation of inflation. Thus, taking a 30 year endowment and assuming an average allotment of $20 paid-up addition per mille sum insured, this would increase the face value of $1,000 by $600 at the time of maturity of the policy. Mr. Pedoe stated that the idea was acceptable to the public on this side of the Atlantic, for in the case of his company in Canada over 90% of the participating policyholders elected this form of bonus distribution on entry; they had the option to change to a cash dividend at any time, he added.

Mr. Pedoe also referred to the compound reversionary bonus system, which penalized the policyholder who cashed his bonuses, thus encouraging the accumulation to offset inflation. He also referred to the special bonus paid on maturity (or death) by at least one British life insurance company in Great Britain, which was in addition to the annual allotment and was due to increased earnings on equity shares. Mr. Pedoe stated that together they more than offset the inflation which had occurred on a 30 year endowment maturing at the present time.

MRS. JULIA S. OLDENKAMP presented Lincoln National's opinion that the lower mortality of females can best be recognized by premium reductions for women, varying by age and plan, using actual age values, reserves and dividends, if any. The reasons for this preference were (1) the actual female mortality experienced can be reflected more accurately; (2) since cash values and dividends are not adjusted, net costs for females are always lower than for males; and, other things being equal, net costs are usually lower than by the age differential method; (3) its legality cannot be questioned; and (4) it eliminates new calculations otherwise required for plans such as Life Paid-up at 65 and Endowment at 65.

Mrs. Oldenkamp indicated that if policies are graded by size, there is no longer any theoretical justification for not using different rates for females. However, she said that because of the deficiency reserve problem it may not be practicable on nonparticipating policies to grant lower premiums to females.

Mrs. Oldenkamp stated that the Lincoln National, after a year of issuing business on a graded premium basis, had not encountered many, if any, of the disadvantages which were predicted. One predicted disadvantage was that there would be continual agitation to combine policies whenever a new application is made. It has never been their practice to combine policies unless they had a common date and were on the same plan. Only a few questions of this type have arisen. Keeping agents informed as to the practice in this regard should virtually eliminate the problem.

Another predicted disadvantage was that the policy fee system tends to produce prohibitive premiums for small amounts. They have set their minimum policy at $1,500 to alleviate this condition. With a fee of $7.00 per policy the maximum fee per $1,000 is thus $4.67. Certainly, from an economic viewpoint, a $1,500 minimum can be justified. They have had a few problems with this minimum. Their main problem has been with small additions to pension trusts where regular policy plans had originally been used. Another problem has arisen on juvenile insurance where small policies had already been issued on children in one family and a corresponding policy was desired on a new child. Usually these are educational endowments and they have merely suggested a longer endowment for at least $1,500 insurance, with the cash value being used to provide the educational benefit. The total premium is thus kept somewhere near that which is being paid on the older policies.

On nonparticipating policies, grading premiums accentuates the deficiency reserve problem since the resulting premium per $1,000 for

large amounts is lower than a flat rate would be. In many instances, especially for larger policies, the Lincoln must set up deficiency reserves on two nonparticipating plans. However, because of a peculiarity of the Kansas law, the Lincoln's rates for these two plans in Kansas for the larger amounts are higher than those used elsewhere.

Their Policyholders Service Department pointed out another problem which may become significant in the future. It concerns the need to split up a large policy for ownership purposes. Policyholders will, no doubt, object to having an increase in premium in order to make a multiple assignment and the presence of multiple assignees of one policy can easily lead to difficulties for the insurance company whenever one assignee wants to make a change, especially if any of the assignees are minors. This problem is likely to be present under either method of grading premiums.

MR. JOHN PHELPS explained that the Lincoln National reinsurance department used the age setback method, rather than special tables that Mrs. Oldenkamp indicated the ordinary department favored, because of different problems involved and not because of disagreement with basic principles.

MR. D. G. SCOTT stated three theoretical disadvantages predicted by Mr. Fassel in his paper for the policy fee method of grading premiums: prohibitively high premiums for small amounts, agency pressure to consolidate policies, and the difficulty of expressing a fee as a deduction. Mr. Scott gave the following observations which he said were the result of eighteen months of experience with the policy fee method. The Continental Assurance departed from the policy fee method on smaller policies, charging $2.50 per $1,000 up to $4,000 and $10.00 per policy on all policies of larger size. Pressure to consolidate comes at issue, which is an advantage. The most usual case occurs when an application for a policy is accompanied by a request for additional coverage. Under the old system an additional policy was issued, with the result that frequently two policies were placed in force. Under the new system an alternate is made for a larger amount which the agent attempts to place instead of the original, so in either case only one policy is in force. There was some reluctance on the part of the agency force to accept the policy fee idea. Mr. Scott said that they have not made up elaborate schedules showing average policy costs per $1,000 because they felt it would destroy the advantage of simplicity. They do, however, emphasize in all sales literature and illustrations that if a policy larger than the one illustrated were purchased, each additional thousand would be at a lower rate than the one used in the illustration. The system

now has the wholehearted support of their agency force and they believe that they have successfully made the transition.

Mr. Scott indicated that a problem existed involving the premium calculations made by agents particularly in brokerage business, but that having the rate books draw attention to the method of calculation on every page kept this problem to a minimum. Also a problem arose where applications were made for a certain amount of life insurance and a smaller amount of double indemnity or disability benefits. They issue two policies, resulting in an additional charge of $10.00 per annum, causing pressure from the field to issue supplemental benefits in such a way that there would no longer be a constant relationship between the face of the policy and the supplemental benefit.

MR. B. F. BLAIR added further to the discussion on the policy fee method of grading by explaining Provident Mutual's method. This method is called "Quantity Discount" and allows a discount of $2.00 yearly per $1,000 on the portion of the policy over $4,000 of insurance. He also mentioned that they changed the method of calculating installment premiums. This new method involves a percentage charge (lower than that previously used) to cover loss of interest and of premiums in the year of death. The expense of the extra premium collections is taken care of by including in the actual installment premium for a policy a collection charge of $.50. A table showing, for all common amounts of insurance, the net amount of the "quantity discount" and the "collection charge" combined is included in their rate book for convenience in making calculations. There is then only one extra step required to bring both "quantity discount" and "collection charge" into the calculation of a premium.

Mr. Blair also indicated, as had Mr. Scott, that the transition was easier than expected.

MR. E. G. FASSEL stated Northwestern Mutual varied premiums by charging a different rate for each of three size groups. In addition they applied the principle of varying rates by size of policy to all prior issues on a premium paying basis through steps in the dividend rates. The size groupings used are the same as for new issues but the steps in the dividend rate are smaller because these do not benefit from commission and premium tax savings. Mr. Fassel also gave figures indicating what he called a significant effect in upgrading of policy size. He indicated, as did the others, that the gradation principle is popular throughout the home office and the field.

Northwestern Mutual has found no great difficulty with requests to merge existing policies into a single policy for rate advantage, although

its rule is quite strict. It will merge policies only where the plans and policy dates are identical. Their manual of information lists the following areas of caution for agents in connection with mergers:

1. Discrepancies as to nonforfeiture and dividend directions must be reconciled.
2. If one policy only has indebtedness, the merger is to be requested under it; if more than one policy has indebtedness, this must be consolidated through a new loan agreement.
3. If there are assignments which differ, a priority of interest must be determined, usually by a new assignment.
4. Differences as to payee and settlement options require revised directions.
5. Difference in ownership prevents merger, but this is not to be confused with a situation where the ownership is vested in more than one person and where all owners act jointly.
6. Policies with common policy dates but with different renewal dates may be combined only after the renewal dates have been returned to the original policy date and after premiums under all the policies have been paid to a common date.

MR. E. J. MOORHEAD gave a reason why premiums (or dividends) need not necessarily be differentiated by sex even though they are graded by size. He said that in some companies the factors used to grade by size may cover only part of the true expense differential, and the average policy within each size bracket may be considerably smaller for women than for men. If this is so, the extra unit cost on the policies on women may be treated as an offset to the mortality saving.

EMPLOYEE BENEFIT PLANS

Coverage for Small Groups

How do the premium levels for Group Life and Group Accident and Sickness contracts covering less than 25 employees compare with those in use for contracts covering 25 or more employees? What has been the claim and lapse experience on this business? What are the costs of administration? Is experience rating practical?

MR. J. K. KITTREDGE described The Prudential's plans for groups of 4 to 24 employees. These plans make available life insurance with accidental death benefits, loss of time insurance, and hospital and surgical coverage. The majority of the plans written contain all three types of benefits. Variations in the amounts of the benefits are permitted but other features are quite standardized. For example, all of the loss of time benefits have been written on a 13-week plan, although the weekly benefits may range from $20 to $50, or provide $35 to $50 for the executive and supervisory employees and a lower amount for all others. A new major medical type benefit was recently made available. This benefit resembles a basic or comprehensive major medical, differing only by the addition of certain controls. The most important of these controls is the scheduling of the maximum charges for the professional services which are eligible under the contract.

For ages over 40, the Prudential uses the same life insurance rates as would apply to regular Group life insurance, but applied by age bracket for administrative simplicity. The rates for ages under 40 have been increased slightly above minimum Group life rates to obtain some additional margin for administrative expenses. Accident and health coverages are written at rates which are about 10% higher than their normal Group accident and health rates. They did, however, adopt the approach of grading the rates by age—a technique which they do not follow in the same way on their business over 24 lives.

Their life and loss of time claim experience has been very satisfactory. They experienced the same general increase in claim costs of hospital and surgical coverages for their small groups as has developed for their larger groups. This trend has continued to the point of producing unsatisfactory claim experience. The rate of case lapse for their small groups has been satisfactory—an annual rate of about 9%. There has been a rather steady shrinkage, however, of the participation under the cases which remain. The enrolling of employees under these small groups

requires much more individual sales effort than do larger groups. This may be because small employers do not have personnel departments equipped to handle this job. The bulk of their small groups cases are written through their district (debit) agencies. The premiums for these cases are collected on a debit basis with the agents receiving compensation for the collection and servicing function. They believe that the success of their small group program, particularly for the 4 to 10 life range, has been primarily due to the close contact between agent and policyholder resulting from monthly premium collections by the agent. Standardization of the plans has also helped to make possible low expense rates. In addition, all of the servicing of the accounts is handled by the agents. Their salaried group field men do not get involved in any way in these small group cases.

Mr. Kittredge did not believe that experience rating is either practical or desirable for these small groups. They do, however, watch their claim experience by geographical area, especially for hospital and surgical expense coverage. Poor experience in a particular area may lead to different plans better suited to local conditions or it may lead to increased premium rates on an area basis. Recently they found it necessary to combine both of these actions in parts of Canada.

MR. R. H. HOFFMAN outlined the features of the Equitable Life Assurance Society's plans for groups of 10 to 24 employees. All plans must include life and accidental death and dismemberment coverage. Weekly indemnity and medical coverages are optional. The life insurance benefit varies from a minimum of $2,000 to a maximum of $10,000, with an equal amount of accidental death and dismemberment insurance. The weekly indemnity benefit is "nonoccupational" with a 7-day waiting period for sickness, no waiting period for accident, and a maximum of 13 weeks of benefits for any one period of disability. Weekly benefits range from $21 to $42.

The hospital expense plan provides daily room and board benefits of $8, $10, $12 or $15. Additional charges up to 10 times the daily benefit are payable in full, plus 75% of charges in excess of 10 times daily benefit. Maternity benefits of 10 times the daily benefit are provided only for employees with family coverage—for pregnancies occurring while covered under the policy. There is a choice of a $200 or $300 surgical schedule and an in-hospital medical expense benefit of either $3 or $4 a day for a maximum of 70 days.

Currently, they have in force almost 600 groups with an average size of about 13 employees and an average premium of $110. The average amount of life insurance per case is $40,000. Their premium levels for

these groups are about the same as those for groups of 25 or more employees. For administrative convenience their life insurance premium rates for small groups vary by five-year age classes and are constant for ages 40 and under. For the calendar year 1957 their loss ratio was slightly under 70% while the lapse ratio was about 8%. They feel that this is a satisfactory result for business of this type. Although they have not made a detailed study, they estimate their administrative expense to be about 10% of premiums, with acquisition expenses, exclusive of commissions, amounting to an additional 20% in the first year. Experience rating of this type of business would necessitate maintaining individual case records and increase the cost of administration significantly. Since their over-all experience has been satisfactory, they do not believe individual case underwriting is required.

MR. R. H. McMILLEN summarized the Travelers' coverage for groups of 10 to 24 lives as follows:

Group Life is issued with premium waiver disability provision and provides for an additional benefit in event of accidental death. Coverage per employee is subject to a maximum of $10,000 and a minimum of $2,000.

Weekly Indemnity Insurance is available in three plans, namely: 1-8-13, 1-8-26 and 1-8-52, and each provides a six weeks maternity benefit.

The Hospital coverage provides for 70 days of hospitalization and covers miscellaneous charges up to 20 times the daily room and board rate. The maternity benefit is 10 times the daily room and board rate. Surgical benefits are in accordance with Travelers' standard surgical schedule, with a choice of a $200 or $300 maximum. In-Hospital Medical Expenses are reimbursed at the rate of $3, $4 or $5 per day with an over-all maximum of 70 times the daily rate.

For Laboratory and X-Ray the maximum is $25, for Supplemental Accident it is $300, and for Poliomyelitis Expense Insurance it is $5,000.

Supplemental Major Medical coverage, although originally offered with a calendar year benefit period, is currently issued with a two year benefit period and total disability is required. There is a corridor deductible equal to 2% of annual salary, subject to a minimum of $100 and a maximum of $300. The covered charges are subject to 25% coinsurance and a $5,000 maximum for any one cause.

Each contract must include Group Life and all coverages except Weekly Indemnity and Group Life are available to dependents. Employees who have eligible dependents may not enroll for employee coverage alone.

Mr. McMillen stated that they have not yet made any attempt to determine the expenses produced by this small group program. However, in view of the economies incorporated in their administrative procedures, they believe they are experiencing satisfactory expense ratios. The premiums applicable to this small group program are essentially the

same as those for larger groups except that certain modifications are made for reasons of simplicity. For the calendar year 1957, this program produced earned premiums of approximately $2,000,000 for Group Life and $1,700,000 for Group Accident and Health, while for the same period the ratio of incurred claims to earned premiums was approximately 55% for Group Life, and 80% for Group Accident and Health. As of December 31, 1957, they had approximately 3,600 small group contracts in force. Of this total, 50% had Group Life only, 25% had Weekly Indemnity, 40% had Hospital, Surgical, etc., 20% had Laboratory and X-Ray, etc., and 10% had Major Medical coverage. The approximate lapse rate on their small group risks for calendar year 1957 was slightly less than 5%. Their experience rating plan is applied to the individual risks of their small group program; however, the experience of the entire class of small group risks is considered rather than the experience of each risk.

MR. J. D. BROWN, in response to a question, replied that the Prudential permits conversion to a regular group policy when the number of covered employees increases to 25.

MR. BROWN and MR. HOFFMAN indicated that their companies' group representatives have nothing to do with these less-than-25-life groups and receive no bonus or production credit for this business. Apparently they and MR. McMILLEN's company all require that group life and accidental death and, except for The Travelers, dismemberment coverage must be included as base coverages in order to obtain A & H coverage. About half of all cases include only these base coverages. All three companies use "group underwriting" for groups of 10 to 24 employees. The Prudential, which also writes groups of 4 to 9 employees, uses a modified type of individual underwriting for these smaller groups.

MR. HOFFMAN clarified his statement on the life amount limits. Rather than relate the maximum to the average amount, as is common on regular group life insurance, choice in his company is limited to one of several available plans, some of them flat and some graded.

MR. G. I. HILLIARD pointed out that the requirement of "total disability" for major medical benefits, as described by Mr. McMillen, might present difficulties on dependents' claims.

Pension Plans

A. What is the present outlook for the spread of the variable annuity concept among (*a*) insured pension plans and (*b*) trust fund pension plans?

B. What information is being included in actuarial reports as to actuarial meth-

ods and assumptions used (*a*) for noninsured pension plans and (*b*) for insured deposit administration plans?

C. Is there a demand in the United States or in Canada for special pension plan provisions for widows and children similar to those in effect in Great Britain? How are such provisions being funded?

MR. L. E. COWARD stated that the variable annuity concept has not found much favor in Canada. Perhaps half a dozen organizations have or are preparing such plans. Recently, in Canada, the cost of living has been going up while common stock prices were falling. This would tend to discourage adoption of the concept.

Registered retirement savings plans offer the individual an opportunity to invest in equities. However, at retirement a fixed dollar annuity must be purchased. This, plus possible dividends, is all that the Act allows, so that this medium cannot provide annuities varying with equity prices.

MR. B. R. THOMAS had the impression that life insurance companies were more active in promoting the concept than were the proponents of trusteed plans. This type of pension should be generally acceptable to more sophisticated employees, but probably would not be satisfactory for the rank and file. Most of the latter would not understand the reason for any reduction that occurred. Furthermore, a high percentage belong to unions and look to periodic negotiations to keep pension benefits in line with the cost of living.

DR. A. A. GROTH, having come from Europe and having encountered astronomical inflations, believed in variable annuities. The interest in them is emphasized by the UAW-CIO demand, mentioned also by Mr. D. C. BRONSON. This demand is not for a true variable annuity, but for a cost-of-living supplement to a fixed annuity. The last would constitute a minimum payment in any event. Hence, employers would be better off with true variable annuities. However, not all employees would understand them.

This suggests the excess type of variable annuity. Unfortunately, the Internal Revenue Service has created a stumbling block in the form of a decision that, under this type, the amount actually paid to the employee can never exceed the limit prescribed by Mimeograph 6641. He felt that this decision does not agree with the regulations relating to money purchase, pension or profit sharing plans.

MR. MEYER MELNIKOFF cited the significant decision handed down on May 22, 1958, by the U. S. Court of Appeals for the District of Columbia circuit, in the case of *SEC vs. the Variable Annuity Life Insurance Company* (VALIC). At issue was the question as to whether variable annuities were securities, subject to SEC jurisdiction, or whether they

were insurance, subject instead to the jurisdiction of the state insurance departments. The Appeals Court unanimously upheld the lower court's ruling to the latter effect. The decision recognized that:

a) Need existed for some such experiment.
b) The most important risk that the purchaser shifts to the company is the risk that he will outlive his funds.
c) Congress intends, for the present, to leave insurance supervision to the various states.
d) Elements of similarity may be noted between such contracts and traditional annuities.
e) "The VALIC contracts . . . depart from the tradition only in their attempt to solve a problem badly in need of solution."

Undoubtedly, this decision will encourage the spread of the variable annuity concept among insured pension plans. This concept is involved in about half a dozen fairly small insured pension and profit-sharing plans in America, including some on a group basis, and in one fair-sized case in England.

Among uninsured plans, the idea continues to spread, with over 30 such plans now in effect, mostly rather large ones. Last year the Wisconsin legislature authorized variable annuities under three state retirement plans. Other groups are giving variable annuities serious consideration.

MR. E. D. BROWN, JR. elaborated on the situation in Wisconsin mentioned by the previous speaker. Variable annuities are now available under the Wisconsin Retirement System, the State Teachers Retirement System of Wisconsin, and the Milwaukee Teachers Retirement System. The variable annuity is entirely optional with the employee. He can stay out, or elect irrevocably to come in. In event of election, half of the total contributions then go to the variable annuity portion of the system. Thus it resembles the plan of the T.I.A.A., with part of the benefit in fixed dollars, and part in variable annuities. The total is supplemented by Social Security. Mr. Brown believed that this is the first time that the variable annuity concept has been included in a retirement plan for public employees.

As to the extent of utilization of the option by employees, it is too early for accurate figures. It is evident, however, that personnel in the upper salary brackets are much more apt to elect the variable annuity feature. To date, about 40% of a typical administrative group have chosen to participate, against less than 10% of the rank and file of public school teachers.

Answering a question, Mr. Brown gave as the reason for the irrevo-

cability of the option, once elected, the fairly obvious one of preventing its use for speculative purposes.

MR. J. K. DYER, JR. commented that most public pension plans are traditionally underfunded, whereas a variable annuity plan, by its very nature, must be kept fully funded. He also observed that public pensions have traditionally avoided investment in common stock, and asked if the Wisconsin plan might not lead to complications through acquiring control of the issuing corporations.

MR. BROWN replied that Wisconsin retirement plans have for some years had statutory permission to invest substantially in common stocks. The present limit is 30%, but full advantage has not been taken of it. The new legislation contemplates that all or most of the variable annuity portion will be invested in equities, but that the fixed dollar portion will be subject to the same restrictions as life insurance company investments. He conceded the possibility of acquiring control of corporations.

MR. D. R. ANDERSON pointed out that in some situations the effect of inflation on the real value of pensions can be minimized without resorting to either the variable annuity or final average salary methods. The method which he had in mind involved the use of a flat rate pension financed by contribution of a fixed percentage of payroll. As salaries rise the fund develops a surplus which can be used to improve the benefit formula for pensioners and active employees alike. In a teacher's plan with which his firm, Eckler and Company, is involved, such a method is followed with respect to employer contributions. Employee contributions are applied on a money purchase basis so that higher paid employees get a somewhat higher pension than those that are lower paid. The method seems to work well, he said.

MR. COWARD opened the discussion of section B by stating that not very much technical information was included in Canada. The employer, for whom primarily the report is prepared, is not much interested in actuarial assumptions and formulas. The minimum that will satisfy the tax authorities is included. He felt, as did DR. GROTH, that the report should also be intelligible to another actuary.

The "Blue Booklet," issued by the Canadian Department of National Revenue, and later withdrawn but not yet replaced, lists the following report requirements for trusteed plans:

a) brief history of the fund;
b) plan description;
c) actuarial assumptions, and reasons for adoption;
d) summary of coverage and valuation results.

In practice, the Department will accept less. The reason for this is that, at plan inception, the Department of Insurance examines the actuary's valuation, including, customarily, his worksheets.

MR. DYER drew attention to items number seven and ten in the recently issued "Guides to Professional Conduct." He felt that the actuarial assumptions, and especially the actuarial method, should be stated. Also, an attempt should be made to describe the underlying funding concept in layman's language.

MR. THOMAS distinguished between the original report prepared at the adoption of a plan, which should include more detail, and the annual valuation reports thereafter. He felt that the reports of most consultants came nearer to meeting minimum requirements than did those of insurance companies for deposit administration proposals and plans.

DR. GROTH stated that his firm, Arthur Stedry Hansen, indicated the actuarial assumptions and method, either directly or by reference to the 1945 Bulletin and published tables. Also, they show an age-service distribution of employees.

MR. BROWN indicated that his firm did not usually furnish as much information as DR. GROTH's, but did state, as a minimum, the mortality and interest assumptions.

Under section C, MR. COWARD noted that there is not much demand in Canada for widows' pensions. The main reason is the general inadequacy of basic pension plans. Also, the tax situation encourages the provision of widows' benefits through group insurance, rather than as a part of a pension plan. Another effect is that the widow's pension is generally a percentage, usually 50 percent, of the man's accrued, rather than of his ultimate, pension. To remedy this, it appears that new legislation and new departmental rules would be required.

MR. THOMAS questioned whether we should regard Great Britain's socialistic program as a model. He added that, in general, the long-term cost of a widow's pension equal to one-half of the employee's pension is about the same as the cost of continuing the full group life amount after retirement. The widow's pension approach gives greater flexibility than the latter, since advance funding is possible for widows' pensions, but not for group life.

MR. DYER suspected that the demand for information and costs on widows' benefits is not going to result in many actual installations. Often the problem is to integrate pension plans, group life plans, thrift plans, and perhaps Social Security, into a widows' benefit plan. This

may not incur any substantial added liability, and might even save the employer money.

As to funding, that depends on existing benefits. If only a small supplement is required, term funding is probably satisfactory. If substantial additional benefits are needed, some regular actuarial funding method should be adopted. If widows' benefits are provided after retirement, supplementary funding is indicated.

MR. C. L. TROWBRIDGE observed that there is a growing demand in the United States for widows' pensions. The pension plan without widows' benefits is obviously inadequate to furnish old age security for both husband and wife. Remember that in two cases out of three the husband dies first.

There is nothing new about widows' pensions for the after retirement situation. Many plans offer a reduced joint and survivor pension in lieu of the normal pension. The employee who elects this option chooses a widow's pension benefit in preference to a larger single life pension.

The difficulty with this approach by itself is that the widow's benefit exists only if the husband is alive at retirement. If he has elected the option and dies one day after retirement, the widow receives a pension for life. If he dies one day before retirement the widow gets nothing. Not only is this illogical and conducive to poor acceptance of the plan, but it may create a pressure for early retirement among employees who otherwise would work to normal retirement. This semiforced early retirement of experienced employees is costly to the employer.

The solution to these evils is a widow's pension prior to retirement. The amount of widow's pension may well start small when the eligibility conditions are met, and build up until it integrates just prior to retirement with the widow's pension available after retirement. For example, a widow's pension of 50% of accrued pension integrates very well at retirement with a joint and 2/3 option.

The Bankers Life of Iowa offers an insured widow's pension benefit to be added to a qualified pension plan. It is written on a group reversionary annuity form, in units of $10 per month of widow's pension. Only married male employees are covered. The basic plan may be either insured or trusteed.

DR. GROTH observed that many service-type organizations have already adopted widows' annuities. A few clients wished to provide widows' benefits prior to retirement, and then allow the employee to select some option including a survivor's benefit at death after retirement. This raises two questions.

One is that of the advance election period for the option. He felt that

a plan with a preretirement death benefit, but requiring election of the joint and survivor benefit five years in advance, is a poorly written plan. Allowing the employee to elect this option at retirement instead permits antiselection, but he suggested that the employer should be willing to underwrite this risk. Assessing this risk is difficult. One approach is to assume a cash benefit at retirement sufficient to provide, on very conservative mortality assumptions, either a life annuity or a joint and survivor annuity. This gives some measure of the maximum possible cost of the antiselection.

The other question is valuation of the death benefits before retirement. Reliable data as to marital status of employees are seldom available for a given client, and average proportions of married to total must be used.

MR. BROWN found that, among public employee retirement plans that do not have Social Security coverage, there is considerable interest in widows' and orphans' benefits. Most in demand are provisions similar to the survivor benefits of Social Security. He gave an example of a money purchase plan. In this, at the death of a member with an eligible beneficiary, the amount accumulated to his credit is applied to the cost of survivor benefits, and the rest is financed by the employer.

Health Coverages

A. To what extent is duplicate coverage present in medical expense insurance? What controls have been adopted?
B. What are the advantages and disadvantages of using projection factors in determining hospital and surgical premiums?
C. What steps have been taken to establish or maintain Major Medical Expense protection among retired employees? Has any significant experience been collected?

MR. M. D. MILLER opened the discussion by pointing out that the most reliable estimates of the extent of duplicate health insurance coverage are those made by the Health Insurance Council in connection with its Annual Survey of the Extent of Voluntary Health Insurance. The survey shows that about 15% of the persons covered for hospital, surgical, and medical expense insurance are eligible for benefits under more than one policy. This figure includes duplication with Blue Cross and Blue Shield. Some of these are covered under more than one group plan; others have a combination of group and individual policies. It is clear, he pointed out, that any resulting overinsurance is bad from an underwriting point of view. Perhaps more importantly, in view of the need for the complete cooperation of the medical professions, it

tends to create public relations problems with doctors. They see people collecting more in insurance benefits than their charges and seeming to make a profit as a result of their services. What to do about it is another matter which various industry groups have studied from time to time at length. One of the difficulties is the absence of a satisfactory standard against which to measure overinsurance. Under the basic hospital, surgical, and medical expense coverages, possible controls lie mostly in closer attention to underwriting and the elimination of situations where duplicate coverage may arise in the future. He believed we should decline to cover the husbands of married women as dependents on the basis that they usually will be eligible for coverage through their own employment. It is interesting, he noted, that the health insurance legislation recently passed in New York recognizes the problem in connection with the conversion of group health insurance benefits. Where the individual has other similar benefits, the converted policy need not be issued or may be terminated.

With respect to the basic coverages, Mr. Miller felt that some duplication can be rationalized on the basis that there are usually other medical expenses at the time of illness that the plan did not cover and which could be regarded as being offset by the additional benefits of a second policy. Under major medical expense insurance, this rationalization does not help because substantially all medical expenses are covered, although not necessarily in full. Fortunately, the major medical expense benefit structure has made it possible to do something specific about it. The Equitable Assurance Society's major medical policies include a provision adding to the deductible the amount of benefits payable under any other group plan or plans toward the cost of which any employer makes contributions or payroll deductions or any labor union makes contributions. This has the effect of eliminating from benefit what is payable under a second group plan, and is a required provision in their major medical plans almost without exception. They have not thought it practical to attempt to exclude benefits under individual policies. In administering the provision, they include a statement in their claim form asking the claimant whether any of the hospital, surgical, or other medical expenses involved in his claim are covered by group insurance or a plan through any other employer or labor organization. In the employer's part of the claim blank they also ask whether he has any knowledge or information which would indicate whether the claimant was covered by another plan. If so, they expect the employer to secure for them the necessary information concerning the benefits paid by the other plan. Mr. Miller indicated that some employers have not been too happy over this, but for the most part they

are cooperating pretty well. While there are undoubtedly some duplication situations not reported, they believe they are getting most of them.

Mr. Miller described the Equitable's procedure if two members of the same family are covered by different group major medical plans and each has a policy provision similar to theirs. In such cases they believe that the plan where the person is covered as an employee should first make its payments; then if their plan is more liberal than the other, they make any excess payments that would arise out of the application of their benefit formula. If children are covered under the father's and the mother's separate plans, they take the position that such coverage is the primary responsibility of the father and that the company which insures the father should first make payment with respect to the children. These rules seem to have worked pretty well in the few cases that have come up so far.

Turning to section B, Mr. Miller called attention to rising claim costs. In connection with major medical costs, he anticipated a rise of perhaps 5% a year. Under a one year term contract, the question, as he saw it, is not so much one of whether to anticipate the rising costs in premium levels: it is more a question of how often should we be required to change new business premium rates and how much must we chase rising loss ratios on existing business. Too often and too much under present competitive conditions, he felt, premium margins are so thin that it is practically impossible to make much provision for future increases in health care costs. Not only is this serious from a company financial standpoint, but it is most unfortunate from a long-term customer-relations point of view. The frequent changes in new business premium levels and the constant need for upward revision of renewal premium rates tend to undermine the confidence of policyholders in health insurance. He decried the fact that price leadership toward higher premiums and more adequate margins (so that better provision can be made for future cost increases) always seems to be something "the other fellow can do better." He believed the trouble starts at the selling point where gross cost often assumes too much importance. We need, he continued, to reorient the buyer to have a better understanding of the nature of our product. We must try to get across to the purchaser a fuller appreciation of the fact that health insurance costs may be expected to rise as health insurance spreads, as medical care continues to improve, and as general economic inflation goes on. Then, perhaps there will be less attention paid to the initial gross premium rates and more adequate margins can be built into the rates so as to anticipate future rises in cost more adequately and to make changes in premium levels less frequent.

As for section C, Mr. Miller expressed the belief that the Equitable

has taken a somewhat more liberal attitude toward the continuance of benefits after retirement on major medical expense plans than have some other companies. Because they wanted to encourage the continuation of benefits after retirement, they have for some time readily offered to continue major medical expense benefits on pensioners, subject to a $2,500 lifetime maximum for each individual covered. They will go beyond this point and offer a higher maximum, even to the extent of continuing full benefits, provided the policyholder understands the cost implications. They urge that the continuance be at the expense of the policyholder, if possible, and in any event that the retired person contribute no more than he was contributing as an active employee. Where fewer than 5% of the employees covered are retired employees, the experience on retired employees is merged with the active group as a matter of administrative convenience. Where more than 5% of the lives are retired, a separate premium rate is established for the retired lives and separate experience is kept for them. They do not yet have a significant body of separate experience.

MR. G. W. FITZHUGH agreed with Mr. Miller's statements on duplicate hospital and medical coverage. Such duplicate coverage for any claimant not only tends to produce a higher charge for that claimant, but also tends to result in higher charges for everyone else in the future. The Metropolitan Life's practice on this problem is similar to the Equitable's. He decried occasional "broker" pressure to delete the "antiduplication" clause and the short-sighted yielding by some companies to such pressure. He urged all companies to prevent duplicate coverage in order to avoid feeding the fires of inflation of hospital and medical costs. He hoped that all A & H coverages eventually would have prorate clauses, but conceded that this might require permissive legislation. Mr. Fitzhugh also agreed with Mr. Miller that there was too much competitive emphasis on costs rather than on the services which the insurance company could provide for its group clients. Continued emphasis on minimum costs, he believed, would result only in minimum service.

MR. W. C. WIRTH reported that the Life of Virginia's major medical policy contained an antiduplication provision similar to those mentioned by Mr. Miller and Mr. Fitzhugh. They experienced considerable resistance to this provision from predominantly female groups. He thought that the solution here was to swing back to covering only wives (as dependents) rather than dependent spouses. They also experienced difficulty in explaining why the antiduplication clause did not include individual as well as other group coverage. Mr. Wirth called attention to the practice of group salesmen representing companies which did not use an anti-

duplication clause to use this fact in competition. He joined the previous speakers in urging all companies to prevent duplicate coverage in order to avoid rapidly increasing costs and, ultimately, socialized medicine.

MR. MILLER, in response to a question, explained that the Equitable's antiduplication clause refers to "any other group plan or plans toward the cost of which any employer makes contributions or payroll deductions or any labor union makes contributions." A Blue Cross plan would be considered a "group" plan for this purpose. Continuing, he asserted that the industry had been short-sighted in not doing something earlier about duplication of hospital and surgical coverage. He felt that the newness of major medical provided a unique opportunity to start all over again.

MR. HOWARD YOUNG suggested the use of a premium refund to combat the argument against the antiduplication clause to the effect, "I am paying for it. Why shouldn't I collect from two plans?" MR. FITZHUGH pointed out that a contribution refund to the employee would be complicated because his contribution is normally not itemized for the various group coverages. Furthermore, in view of the employer's contributions, the benefits provided for the employee (even with the antiduplication clause) are normally a bargain compared with the employee's contribution. As for the employer, the savings produced by the clause eventually result in lower employer costs through experience rating.

MR. S. W. TOMPSON, JR. suggested the use of a deductible in hospital coverages to control the increasing utilization of hospitals. MR. MILLER agreed that such elements of plan design would be helpful in controlling rising claim costs but pointed out that they are frequently unacceptable to the purchaser.

Impact of Social Security

A. To what extent has the disability Insurance Benefit of the U.S. Social Security law (payable since July 1957 to qualified disability cases over age 50) affected privately operated insurance and retirement plans for employees? Have adjustments been made in private plans to integrate disability benefits thereunder with those provided by Social Security.

B. What would be the effect on insurance company plans, and on Blue Cross and Blue Shield, of the enactment by Congress of proposals to provide hospitalization and surgical benefits, and nursing and home care following a period of hospitalization, for persons *eligible for* Old-Age and Survivor Insurance benefits? What problems would be encountered in attempting to estimate the cost of such benefits?

DR. J. P. STANLEY pointed out that the new OASI disability insurance benefit has primarily affected two classes of private plans: (i) those already integrated, and hence requiring no specific amendment; and (ii) unintegrated plans providing disability benefits in excess of accrued retirement benefits. The latter class, however, generally provides for an offset of all or part of any other public disability benefits. Most of the plans appear to have been amended so that at least the accrued retirement benefits will be paid on disability, on the theory that the combined public and private benefits of the disabled employee should reasonably be on a par with those for employees retiring at 65 with the same service.

Two other related problems have usually been handled by administrative fiat, although sometimes by amendment. One is the elimination of double deduction of Workmen's Compensation benefits. The other arises from the delay in eligibility determinations. The most common solution is to assume that an employee will qualify for OASI disability benefits if he applies, and then to make a retroactive payment from the private plan should he eventually fail to do so.

MR. R. J. MYERS commented on several trends. He estimated that almost half of the private plans with disability benefits have a Social Security offset, sometimes of long standing. However, in reviewing group annuity booklets describing new plans since July 1956, he found that less than 1% actually mentioned the availability of disability benefits. In earlier plans, disability was frequently an alternate requirement for early retirement benefits.

Initially, many private plans had Social Security offsets to the age retirement benefits. This has proven unsatisfactory, especially whenever Social Security benefits were increased. Accordingly, there has been a distinct trend away from this, and this same trend seems to be setting in rapidly in regard to disability benefits. The plans of the steel and automobile industries now have essentially the same formulas for disability as for age retirement, and none of them involve deduction of the exact amount of the Social Security benefit.

With DR. STANLEY, he noted that, currently, OASI disability is being more strictly administered than are most private plans. Through April 1958, more than 900,000 determinations had been made, with only 52% approved. This, of course, does not mean that only half of the disability cases under private plans are declared eligible for Social Security benefits.

There is a considerable difference in the exposure for disability benefits under private plans and under OASDI. Thus, private plans generally

grant benefits only to those with considerable service with the particular company. Under Social Security there is not only this group, but also the sizable group who move from job to job and who probably are more prone to disability, by not having seniority rights and relatively good incomes. On the other hand, under many private plans disability benefits may become payable before age 50.

Mr. Myers understood that their determination of disability is often accepted, despite an earlier adverse decision under the private plan. This is indicative of the problem that private plans must face—and undoubtedly must go along with—even though the reverse situation may not prevail. One large multi-employer plan has a rather unique method of handling disability cases. If the Social Security Administration rules that disability is present, the private plan pays a disability benefit 10% higher than the actuarially determined early retirement benefit. But if they reject the claim, then only the regular early retirement benefit is payable.

To the discussion on determination of disability, MR. J. K. DYER, JR. added a comment. In a German plan in which he was involved, he was rather shocked to find that they wanted to define disability as being a state of health such that the government would pay benefits under the national plan. To his objections, they answered that this was the normal and universal thing to do.

Turning to section B, Mr. Dyer stated that, from a short-sighted standpoint, the Blue Cross and many employers would welcome such legislation. It would shift some of the disproportionately high hospital and surgical costs on the older group to the taxpayers. However, from a long-range standpoint, this is one of the most serious proposals made since the inception of Social Security. It is the first time that anything other than cash benefits has been proposed. The next step would be the extension of such benefits to those entitled to disability benefits under Social Security at a very great increase in cost. The logical end result is socialized medicine. As a consultant, he felt that one of his duties to his clients is to make the long-range implications of Social Security legislation clear to them.

MR. D. R. ANDERSON asked as to the attitude in the U.S. toward the development of plans similar to the Canadian Federal-Provincial Hospital Insurance Plans. MR. DYER felt they would be undesirable in the U.S. along with any "foot in the door" toward socialized medicine.

In an exchange between MR. M. D. MILLER and MR. DYER, it was brought out that the provisions of the Forand and similar bills were not restricted to the aged, nor even to those actually receiving

Social Security payments. Mere eligibility to currently receive any benefit is all that is required.

DR. J. P. STANLEY emphasized that there is a genuine need for hospital coverage for retired employees. Opposition to such legislation is not enough. The only long-range solution is to fill the need through private plans. Some of the Blue Shield programs and certain insurance companies are attempting to do so.

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INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

Problems Arising from Legislation

What problems have arisen from the recent enactment in certain states of legislation limiting a company's right to cancel or to refuse to renew individual accident and sickness policies? What steps have been taken to meet these problems? What problems may arise from similar legislation now being considered by certain state legislatures?

MR. H. A. LACHNER gave a summary of the recent legislation in New York State relating to individual accident and sickness insurance, referring specifically to the requirement for a 10 day approval period for policyholders to examine their policies and a conversion privilege for persons ceasing to be within the definition of family, and to the provisions relating to restrictions on cancellation and nonrenewal. He believed it is well that this limitation is not required to appear as a policy provision. This reduces the danger, as in cases of moral hazard, of the need to disclose to the policyholder the reason for nonrenewal. Support for nonrenewal because of overinsurance may be given by a statement of rules regarding the company's maximum participation limits in the case of hospital and surgical. Duplication of major medical would lead to nonrenewal. He felt that deterioration of health could be properly insured and refusal to renew solely for that reason is not justified.

In reply to a question, MR. CARLTON HARKER and MR. E. L. BARTLESON said that this new legislation as it pertains to hospital policies brings the regular commercial policy under the Task Force 4 definition of guaranteed renewability and the active noncancelable reserve would be required. This, however, is not high in hospital policies.

MR. LACHNER referred to the New York Insurance Department report on "Voluntary Health Insurance and the Senior Citizen." It quotes 10% as an illustrative addition to the net premium when a full guaranteed renewal provision is added. MR. LACHNER and MR. HARKER felt that this was much too low except for a company which had been exercising its right of nonrenewal only very sparingly in the past.

MR. J. R. JAMIESON, in reply to a question, said that in certain geographical areas there are underwriting problems which prevent the writing of noncancelable business. MR. HARKER stated that legislation would tend to cause insurers to withdraw offerings to certain risks such as over-age and borderline substandard and fully substandard, creating a vacuum which might open the way for Federal medical insurance.

In reply to a question as to whether anyone had received approval of a prorating clause for duplicate coverage, MR. BARTLESON said that, under the uniform law, benefits could be reduced only if the application for insurance did not reveal the existence of other coverage.

Underwriting and Administration

A. Can the problem of duplication of coverage or overinsurance in hospital and medical expense coverages be met by
   1. Underwriting procedures?
   2. Claim administration?
   3. Policy limitations?

B. What problems have been encountered by companies which have attempted to provide insurance to impaired risks by means of extra premiums, with respect to
   1. Sales?
   2. Underwriting?
   3. Claim Experience?
   4. Persistency?

C. The use of guaranteed renewable provision with the right of premium scale changes has become widespread in the writing of hospital and medical expense policies.
   1. What problems will confront companies in the future if the need arises to increase premium scales?
   2. For policies intended to be paid-up at age 65, will problems be encountered if insureds terminate coverage in later years without receiving nonforfeiture benefits?
   3. What problems are encountered with policies which are guaranteed renewable for the life of the insured?

MR. G. M. SHERRITT opened the discussion of section A by asking whether any companies had met the problem of duplication of coverage and overinsurance by introducing a policy limitation acceptable to the state departments.

MR. E. L. BARTLESON pointed out that the uniform policy provisions allow reduction of claim payments only in respect to duplicate coverages in other companies about which the insurer had no knowledge prior to the claim. Therefore, in the guaranteed renewable field the law does not permit an effective reduction clause since admission by the insured of duplicate coverage prior to claim establishes his right to subsequent full payment of claims.

MR. J. R. JAMIESON mentioned the problem of making sure, when a policy is issued to replace another policy, that the original policy is terminated. The Prudential attempts to control this problem directly with their field managers.

MR. J. F. RYAN, introducing section B, said that in March 1958 the New York Life introduced a program for issuing noncancelable and guaranteed renewable policies to impaired risks, subject to the payment of an extra premium. Their program follows the traditional life insurance approach in that regular policies are made available to impaired risks and regular premiums are charged plus appropriate extra premiums.

The regular policy form is used with the "pre-existing conditions" exclusion endorsed to make it inapplicable with respect to the particular impairment or medical history for which the extra premium is charged.

Numerical morbidity ratings have been established for each insurable impairment. There are five special classes covering morbidity ratings between 125% and 305%. The ratings were developed after study of all available data, but they necessarily reflect a considerable amount of judgment.

In general there are two ratings for each impairment: one for accident only policies and one for policies with accident and sickness benefits, including hospital and major medical policies. Some impairments are standard for accident only benefits but are rated for accident and sickness benefits.

Premiums.—Since accident and sickness premiums are, in effect, term premiums with little if any investment element, the extra premiums are fairly substantial in relation to standard premiums. Thus 50% extra morbidity requires an extra premium of almost 50% of the standard premium. To minimize practical difficulties on borderline and very slightly substandard risks, the first substandard class covers a very narrow range of ratings.

Extra premiums for loss of time plans generally do not vary by occupation class. In special cases a combination of occupational hazards and physical ratings will lead the underwriter to assign a higher rating for the particular impairment than if there were no occupational hazard present. This approach considerably simplifies the substandard program.

In addition to permanent extra premiums, temporary extra premiums are used for certain impairments.

Underwriting.—Special rules were developed, including the following:

Major medical and long-term sickness plans are not available to highly substandard risks where certain impairments are involved, such as nervous disorders and brain conditions. In the case of certain similar types of impairments, monthly income benefits are restricted to amounts less than the regular limits.

Senior Hospital policies, issued at ages 61 to 75, which provide lifetime coverage are available only in the first three special classes.

Dividends and Commissions.—As is the case for life insurance, it is contemplated that the same dividends will be paid on both standard and substandard accident and sickness policies. Regular commissions will be paid on permanent extra premiums, but no commissions will be paid on temporary extra premiums.

Experience.—Based on a very few months experience, only a very tentative evaluation may be attempted.

Currently between 10% and 15% of new policies are issued with extra premiums. A number of cases are included which would formerly have been declined, such as elevated blood pressure. Between 5% and 10% of new policies are issued with exclusion riders, mainly cases involving elective surgery such as hernia and varicose veins.

In general, substandard business slows up underwriting, processing and issue and requires more complex records. As anticipated, a larger number of medical reports have been required.

An applicant who qualifies for a policy with an extra premium is not permitted the option of electing a policy with an exclusion rider. Complaints from the field force about this rule have been remarkably few.

Conclusion.—The substandard program is highly experimental and is based largely on judgment. Customary statistics to evaluate its success will take some time to develop. Nevertheless, Mr. Ryan expressed the opinion that full coverage on impaired lives is a natural and desirable development and will become a regular and successful part of the accident and sickness business.

The federal government has stressed the need for private enterprise to cover the old age and impaired risk categories. In the past few years much progress has been made in the old age area. Mr. Ryan expressed confidence that the life insurance companies can lead the way in the next great area of expansion, the substandard accident and sickness field.

MR. C. N. WALKER commented that the claim experience on substandard business of The Lincoln National has been favorable although their experience in this new field is too limited to be significant.

In reply to a question by Mr. Walker, MR. J. S. THOMPSON, JR. explained that the New York Life ratings in rare cases indicate different ratings for loss of time and hospital coverages.

MR. CARLTON HARKER discussed the potential area of abuse in the case of an insured with an "elective disability," such as elevated blood pressure or minor heart impairment, who could periodically follow medical advice to "take it easy" and finance his periods of inactivity through disability insurance.

MR. THOMPSON commented that the possibility of "elective dis-

ability" is an important problem in selecting substandard risks. However, it is not a new problem since essentially the same problem arises, although perhaps less frequently, in connection with regular substandard policies.

MR. J. R. JAMIESON agreed with Mr. Thompson that the problem is not a new one. He pointed out that particularly in loss of time coverage the company is insuring a person's moral responsibility as well as his physical condition. He felt that substandard business will produce a larger volume of problem cases for the claims department than a similar amount of standard business. While the substandard field presents many problems, leadership must be assumed by someone. Mr. Jamieson complimented the New York Life on their pioneering efforts.

MR. E. L. BARTLESON, introducing section C, expressed the views of the Prudential. With regard to problems incident to increasing premium scales, Mr. Bartleson emphasized that a change would apply to a whole premium scale according to the original classification of the risk including the original insuring age. In the original premium scale his company allows for the increase in claim rate with advancing age and duration of policy and holds reserves accordingly. Their morbidity and expense assumptions produce premiums on which dividends are expected after initial expenses are amortized. As is the case for participating insurance in general, there is thus some safety margin built into the premium. The right to change the premium scale is the *additional* safety factor considered necessary because of the uncertainty of future utilization of hospital and medical services and the price level thereof.

If the need arises to increase premium scales, the premium after increase will still be less than for similar coverage at the insured's attained age and this will be carefully explained to the policyholders. Although some intensification of antiselection may be expected, Mr. Bartleson expressed the belief that this can be largely overcome by careful presentation of the increase by the company and its field representatives.

With regard to coverage becoming paid-up at age 65, Mr. Bartleson indicated that there are substantial and obvious technical problems involved in the determination of any nonforfeiture benefits on any health coverage. While present tables are probably satisfactory for calculating an aggregate reserve liability, it is yet to be demonstrated that the reserves so computed bear any simple relationship to the individual equities. Since this type of contract has been issued only recently, there is some time to accumulate knowledge before these policies reach durations where termination allowances would be appropriate. Mr. Bartleson suggested that in the near future this problem could be met by termination dividends. It is to be expected that such voluntary allowances will be

instituted and that when they are there may thereafter evolve statutory requirements for nonforfeiture benefits.

The principal problems encountered with policies which are guaranteed renewable for the life of the insured include (1) the very long term risk and the trend toward rising costs, (2) the lack of claim experience at the advanced ages and (3) the possibility of claims for what is really custodial care. The Prudential reduced the risk for the first two by reserving the right to change the premium scale and for the third by providing only for scheduled surgical benefits, and hospital benefits designed for comparatively short confinements, and by excluding from the definition of a hospital institutions classified as rest homes, nursing homes or homes for the aged.

MR. B. J. HELPHAND expressed the belief that the wording of some of the guaranteed renewal provisions obligates the company to charge the same premiums to old policyholders as are being charged for new business. He pointed out that under such circumstances if the company is required to use the original issue age in obtaining the premium for old policyholders there will be a deficiency in the active life reserve whenever a premium increase is made. This would be particularly true if the premium increase were due to inflationary costs of services provided by a policy of the major medical type. In such event the deficiency in the active life reserve will be directly proportional to the percentage of premium increase. For example, if claim costs increase 25% because of inflation, in turn requiring a 25% increase in premiums, the active life reserve is deficient by 25% of its aggregate amount.

The deficiency in the active life reserve could be avoided by adopting a special premium scale for old policyholders which is higher than that for new issues. However, Mr. Helphand expressed doubt that the wording of some of the current renewal clauses would permit that.

In order to avoid large deficiency reserves arising under service type policies such as major medical policies, companies must make frequent premium adjustments where costs are rising as a result of inflation.

MR. C. N. WALKER asked if anyone had gone through a rate change.

MR. H. A. LACHNER commented that rate increases by Blue Cross have made the problem somewhat easier by conditioning the insuring public to increases.

MR. W. V. B. HART related the experience of certain companies which, in 1931, increased the general level of accident rates on commercial policies. Problems were encountered, but the revision was made. Some

of those policies are still in force and are yielding satisfactory claim experience.

MR. ALANSON TOWNE related the experience of the Empire State Mutual. Their most recent increase was about 30% on a closed block of commercial business. They have found that by giving their agents sufficient warning, perhaps sixty days, so that they can contact their clients, the problem is not so severe as the first reaction of the agency force would indicate. They were surprised to find that only ten to fifteen percent of the policies lapsed at the time of the increase and the premium income from this closed group actually increased following the premium increase.

MR. D. J. LYONS told of his experience in a small stock company in 1932. Accident and health was a large part of the company's business and was losing money. Premiums on all business in force were increased, involving complex actuarial analysis due to the variety of benefits in many series of policies. The field force was told in advance of the rate increase and there were surprisingly few repercussions from the field. Mr. Lyons expressed the opinion that if the need for increases should develop, they will be effected with much less difficulty than is anticipated today.

MR. WALKER mentioned the experience of a company which had increased premiums twice. Premium notices reflecting the first increase were accompanied by a carefully worded letter of explanation. This method was quite successful. At the time of the second increase various alternatives, one of which was automatic, were offered the policyholder. The administrative problems and the correspondence which was needed to reduce confusion convinced them that the method involving no alternatives was far superior.

MR. JAMIESON said that from his experience, based on restrictive actions taken in various local problem areas, the agency force will be surprisingly uncritical of actions taken by the company, including premium increases, to control obviously unfavorable experience.

MR. WALKER closed the discussion with the comment that issuing policies guaranteed renewable for life inevitably involves policies issued above age 65. Underwriting problems increase markedly at ages over 65.

Miscellaneous

A. What is the relationship of the H.I.A.A. Statistical Plan to existing plans for the study of Accident and Sickness experience and to the work of the Society Committee on Experience under Individual Accident and Sickness Insurance? Is there need for further expansion of the Society's area of responsibility?

B. Should any changes be made in the present Annual Statement requirements for Individual Accident and Sickness, *e.g.*, Exhibit 9, Column 11 of the Gain & Loss Exhibit, Schedule H, Schedule O, and the Policy Experience Exhibit? Is there need for an equivalent of the Life Insurance Policy Exhibit? Should Schedule H be improved to classify coverages more adequately? What simplifications can be made?

MR. J. S. THOMPSON, JR., in reviewing the history of intercompany morbidity studies during the past several years, cited some of the activities of the Bureau of Accident and Health Underwriters and the Health and Accident Underwriters Conference, predecessors of the Health Insurance Association of America. An important contribution of the Conference was the so-called Conference Modification of the Class III Table, which has been recognized for many years as a valuation standard for disability coverages. The Bureau started sponsoring studies around 1921 and, except for an interruption during the war years, was very active in this field until 1956. Several accident and sickness experience studies were conducted during this period, the latest being the 1948–1951 accident study and the 1952–1953 sickness study. The Bureau studies covered commercial policies and the number of companies contributing to the various Bureau studies indicated that member companies had considerably more interest in accident insurance than in sickness coverages.

The Society's interest in this field dates back about five years, at which time the Committee on Experience under Individual Accident and Sickness Insurance was established. At that time the Society also accepted Individual Accident and Sickness as a suitable topic for papers and discussions at its meetings and Individual Accident and Sickness was added to the syllabus for the Fellowship Examinations beginning with the 1955 examinations. Recognition of this line by the Society seems to reflect the importance of Individual Accident and Sickness as a part of the Life Company's portfolio.

The Society's Committee developed a plan for an intercompany study along much the same lines as the study of Ordinary mortality. It has been designed as a continuing study in order to build up a reliable volume of data as soon as possible.

The initial study now being conducted by the Society has been restricted to the total disability benefit under policies providing at least a one year benefit. It covers all types of renewal provisions and policies covering accident only as well as those providing sickness coverage. Although the Society study could be extended to other health insurance coverages, it was felt desirable to restrict the initial study to loss of time

coverages only. The greatest need for morbidity data has been in this area. Although the Conference Table is still prescribed as a valuation standard, it may be questioned whether it is a satisfactory measure of current morbidity. The Society studies should form a basis for a test of the suitability of this table.

There is probably much greater consistency among the various companies in the types of loss of time benefits currently offered than there is in the medical expense coverages. Many of these latter coverages are still in their experimental stage and the variations in practice among the various companies would naturally introduce complications in an intercompany study. It was also felt that the initial studies should be on as simple a basis as possible in order to avoid an undue strain on contributing companies.

When the Society's program was first announced, there was considerable interest in the study and at one point 80 companies indicated a willingness to cooperate in the study. However, when the request was made for data for 1955, only 11 companies found it possible to contribute. These companies contributed 690,000 policy years of exposure and 50,000 claims. The apparent lack of enthusiasm on the part of potential contributors is explained largely by the fact that many companies have recently installed new electronic systems for maintenance of their insurance records and have found it difficult to participate in intercompany studies during the conversion period. However, many companies have indicated a desire to cooperate just as soon as they are able to do so. In fact, 13 companies contributed 840,000 policy years of exposure and 58,000 claims to the 1956 study. This represents an encouraging increase in the volume of data over the 1955 contribution and an even greater increase within the near future is probable. The study of the 1955 and 1956 experience is still in progress and it is hoped that a report of the Committee's study will be available before very long. Of course, before a report is made, the Committee will have to be satisfied that a sufficient volume of data has been accumulated over an adequate period to form the basis for sound conclusions.

If two or more intercompany studies operate independently in the same area, there is bound to be duplication of effort and unnecessary expense for both the contributing companies and the compiling agencies. While the Society seems to be the logical agency for handling intercompany studies that require detailed actuarial analyses, as in the development of morbidity tables, it must be recognized that there are a number of companies writing a large volume of accident and sickness insurance that have no representation in the Society. These companies

have a great deal of valuable data and also much valuable experience in some of the practical aspects of this line. Consequently, Mr. Thompson felt that it is highly desirable to make morbidity studies a cooperative effort representing the entire industry.

Mr. Thompson advised that the Health Insurance Association of America had had this same question under consideration for some time and that the Actuarial Committee of the Health Insurance Association of America at a recent meeting had appointed a committee to explore this entire area and to recommend the position that the Health Insurance Association of America should take with respect to the collection of morbidity data on an intercompany basis. This committee met on June 4 and drafted a recommendation for action by the Health Insurance Association of America, which he felt would be of interest to the Society in that a similar recommendation would probably be made to the Society. The report to the Actuarial Committee concluded with the following paragraph, which states the committee's recommendations.

> Your subcommittee has concluded that closer collaboration between the H.I.A.A. and the Society of Actuaries should be sought so that the studies currently in progress under the jurisdiction of the Society may benefit from the experience of H.I.A.A. members who are not also represented in the Society, and thus have the widest possible support within the industry. In order to accomplish these objectives, it is recommended that appropriate steps be taken to establish a joint committee representing both the Society of Actuaries and the H.I.A.A. and that the joint committee be requested first to resolve any existing questions with respect to the conduct of intercompany investigations of accident and sickness morbidity and, secondly, where appropriate to act as a steering committee in the planning of future studies.

Feeling that a small joint committee would be able to operate more efficiently, the committee suggested that the joint committee consist of three representatives from each of the two organizations. However, this does not mean that any segment of the industry will not be represented, because the H.I.A.A.'s Actuarial Committee to which the joint committee would be responsible on behalf of the H.I.A.A. represents the entire industry.

MR. J. C. ANGLE of the Woodman Accident and Life Company, a member of the H.I.A.A. Actuarial and Statistical Committee, was invited to participate in the discussion of this topic. Mr. Angle felt that both the title "Statistical Plan" and the topic of discussion were misleading. In the first place, it is not so much a plan as it is an outline of two claim punch cards and two premium or exposure cards, one each for accident and sickness coverage and one each for hospital coverages.

Secondly, the plan has not been introduced as an industry plan for the collection of statistics but rather as a typical plan which a company not already having one might adopt.

Mr. Angle suggested that probably many of those companies which indicated an initial desire to contribute to the Society's study, and then later failed to do so, had failed not from a lack of desire to cooperate but rather from a lack of the technical knowledge of how to construct an exposed-to-risk file. Many simply did not have the desired information in their records.

Many companies writing accident and health insurance have a strong casualty background and, in many cases, particularly among the smaller companies, have set up their statistical systems to produce only those data needed for the annual statement. While from these premium and claim figures they may derive loss ratios by policy form, they are unable to obtain unit claim costs by age, sex, size of policy, and so on. Several of these companies, particularly those lacking adequate actuarial advice, expressed a desire to know more about statistical plans and the H.I.A.A. attempted to help them in this respect. Before a company can consider participating in an intercompany study, it must first have an adequate plan of its own. Mr. Angle felt that the H.I.A.A. plan served well in satisfying this initial requirement.

MR. T. H. KIRKPATRICK called attention to the difficulties encountered in conducting an intercompany morbidity study and expressed himself in favor of the proposal for a cooperative effort. While the actuaries have the technical skill to handle the more difficult morbidity compilation problems, they operate pretty much on a no-budget, voluntary basis. The H.I.A.A., on the other hand, has a full staff which is able to devote considerable time to any project.

Although an up-to-date total disability table is most urgently needed, he felt that there are several other areas of considerable interest, such as travel accident, principal sum benefits, credit accident and health, school coverage, house-confining disability, etc. Mr. Kirkpatrick felt that there is plenty of room for both the Society and the H.I.A.A. in exploring these areas and that more would be accomplished if such studies are directed by a joint steering committee.

MR. G. H. DAVIS stated that Schedule H, added to the life annual statement at the time the statement was modified to cover accident and sickness business, reflects the type of reporting of the Casualty Blank and is somewhat inconsistent with the manner of reporting used for life insurance business. Some of the items reported in Schedule H differ from what appear to be corresponding items in the Gain and Loss

Exhibit. He was also critical of the excessive detail included in Schedule H and felt that the manner of developing earned premiums and other items is in the nature of a worksheet. This requirement of worksheet detail is not consistent with the information required with respect to life insurance.

Another shortcoming of both Schedule H and Exhibit 9 is that the types of coverages called for do not provide appropriate reporting for the different types of coverage currently being issued; for example, there is no specific place to enter figures for major medical coverage. The controversy as to what contracts may be designated "noncancelable" also introduces complications. The proposal made last year to the NAIC Committee on Blanks for a revision of Exhibit 9, which would have brought it more in line with the form of Exhibit 8 for life insurance reserves, failed to be adopted, and although there was objection to the proposal on other grounds, the controversy as to what may properly be designated "noncancelable" had considerable to do with this failure.

There is some argument for adding to the Annual Statement some equivalent of the life insurance policy exhibit for accident and sickness insurance. A proposal was made to the NAIC Committee on Blanks this year for a simplified form of such an exhibit for those policies for which an active life reserve is required in Exhibit 9. The proposal was not adopted for the 1958 statement blank but it is being given further consideration. Although there is some question of the desirability of the life insurance policy exhibit on the grounds that the Annual Statement should be confined to financial rather than statistical reporting, this policy exhibit is the basic source for important statistical data for state insurance departments and for various independent reporting organizations. Some similar source of accident and sickness statistical data would be useful, but Mr. Davis felt that any such exhibit should be made simple enough to avoid excessive amounts of work by the companies.

Some change in Schedule O is probably desirable. There is some question as to the usefulness of Part 2 of the present Schedule O and it may be that the schedule could be eliminated, with the information now shown in Part 1 being incorporated in Schedule H. It also seems logical to designate Schedule H as an exhibit in the Annual Statement rather than as a schedule.

MR. J. H. POWELL mentioned the activities of the Blanks Committee of the H.I.A.A., of which he is chairman. His committee's objective is a proposal which may be submitted to the NAIC Blanks Committee for the revision or replacement of Schedule H, Schedule O and Exhibit 9. This committee, representing both life and casualty companies,

works closely with the ALC-LIAA Committee and also with the Casualty and Surety Committee. He requested that anyone having constructive ideas on the subject send them to the H.I.A.A.'s New York office.

MR. H. A. LACHNER warned against a policy exhibit which would require so much detail that it could be susceptible of yielding misleading information. He felt that if such an exhibit were required it might be sufficient to show the in-force at the end of the year and the issue during the year. By reference to the preceding year's exhibit, terminations could be determined as the balancing item.