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CORPORATE DECISION-MAKING FOR AN INDIVIDUAL HEALTH LINE

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1. How have companies decided which product lines they will market?

2. What factors improve the profitability prospects for a product line?

3. Why do many companies feel that income protection coverages are viable and medical expense coverages are not?

4. Why have other companies concentrated their energy in the medical expense market?

5. Why did many life companies decide to enter the health insurance business at a time when experience was poor?

ALAN N. FERGUSON: A few words of background; we will each introduce ourselves. I'm originally from England. I came to the U.S. in 1958. I've been with the Prudential since then. I've had a variety of administrative and actuarial assignments. Currently I'm responsible for our individual underwriting, for our small group and individual health business, such as design, pricing, monitoring the administrative operations. We are a decentralized company. So that while I'm in Newark, none of the premium notices or the in-force or the claims are handled in our Newark office. They are all handled at our regional home offices. I'm also involved in aviation reinsurance business.

KENNETH J. CLARK: I have spent 10 years as chief individual health actuary for Lincoln National, and then after that about 6 years as chief ordinary actuary for individual life and health insurance. Then for the last 6 months I've taken on a new job or responsibility for all product development work for the life insurance company, Group Annuities, Life & Health. Despite the fact that my current duties are not in health insurance directly I have a long background of health insurance. I hope to share some with you today.

JOHN B. CUMMING: I manage individual health insurance for the Equitable. Since we're going into background I've been in individual health since 1971 and did the actuarial, product and underwriting development work for many years, and then I was out for a couple of years, and now I've been back managing it for the past 2 years. Unlike Alan's operation, our individual health activities are all centralized in a single department with the exception of the sales and sales development and sales management activity, and that's made it a very challenging and rewarding job.

MR. FERGUSON: We'll address the first question which is how companies decide which product lines they will market. I'll start off and give you a little bit of background. Our individual health business is mainly Major

Medical business which currently is about $300 million of premium in force. We have about $30 million of Disability Income premium in force, and we have a small amount of Hospital Indemnity Insurance. Our in-force remains fairly static in Disability Income and we have put the emphasis on Major Medical for a variety of reasons. We wanted to have a complete line of Health Insurance products. We have a substantial amount of Group Health business. We developed small group business which goes back to the 50's. We revised our program extensively in the early 70's. First 10-to-49 lives and then 2-to-9 lives, and we wanted to fill the gap that remained and have a product for individual insurance. We felt if you leave a gap that the government will move in. One of the first laws of health dynamics is "government abhors a vacuum." We felt if they get one foot in the door they go on; and so it is to protect our position in the health insurance market that we felt, unlike many other companies at the time and since, that we would strive to provide an individual Major Medical product. And it's one that is very much like the coverage that is available to groups. It is a very extensive Major Medical product with reasonable and customary surgical benefits and semi-private room rates.

We felt we had acquired some momentum with our small group business, and we went on into the individual health business. I might say the latest development was last year when we added a short term Major Medical product which is available for, under the single premium basis, terms of 3 months or 6 months. We wanted a product for our field force. Our individual business and our small group business is sold by agents, it's not sold by any specialized group representatives. We felt that another benefit of having this product was the entree it provided. It leads to other sales. There is some question about whether that really is effective. We have had a lot of brokerage business. We write a lot of our individual health, and our small group business is written by brokers. Again it's questionable whether that really effectively leads to other business as we had hoped -- to other life business for example. As for the profitability or otherwise of this business, I might say that I was not involved in the early development of it. Jim Olsen, who is now retired, is here and maybe he'd like to comment on some of this since he was involved in the development. I think it's fair to say that we hoped, at least, that this business would be self-supporting. Now what does that mean? You can ask youself shouldn't resources that are committed to the development of a continuation of this product provide a return to the investors, the other policyholders in the company, the life policyholders. Shouldn't it provide a return on that investment commensurate with what we ought to get on other investments? Stocks and bonds for example. In some respects I guess we could be said to have failed in that objective because we have a substantial accumulated deficit on our Major Medical product (we call it CHIP, incidentally). So we have had a substantial deficit on our CHIP product every year since we started in 1973. Last year we about broke even. This year, unfortunately, for a combination of reasons, we will sustain another loss. On the other hand, if we look at the total results of our small group business (up to 49 lives) those results have been satisfactory. We have developed an adequate surplus.

This year, not only will we suffer some losses in our individual health line, but also in the 2-to-49 life range, so that surplus that we developed will be reduced. I contend that the investment in individual health insurance is not the same as investing in stocks and bonds. It might be interesting to have a different perspective from a stock company on this. Maybe Ken will comment on this. One important thing that I hope this business does is contri-

bute to our agents' income. Last year our small group business contributed over $2,000 to each agent's income. So it is a significant element in that compensation. You can ask a number of questions following from that. Could we support the agency force that we have - over 24,000 people - without our health business? On the other hand, perhaps you can argue they could be better employed selling life insurance, concentrating on that rather than engaging in health insurance business. Following that, should we cut our sales staff by eliminating marginal producers? If they didn't have this average $2,000 a year, would that mean that we would reduce our sales staff and might that, in the end, result in better net cost to our life policyholders? I don't know the answer to that. I don't know if anybody does. I would be interested in any comments that anyone in the panel or in the audience might have on that. So much for Major Medical insurance. How about disability income. As I said we have not really done very much in disability income in the last several years. We've maintained a conventional portfolio and the last 4 years our sales have steadily declined for a number of reasons. One is that we've raised the minimum income for eligibility for our products. We've changed the participation limits. Most companies have done this because of Social Security changes. The market for our product really has been reduced by that, and we have not developed up-to-date products such as residual benefits or Social Security riders. One of the problems is, in trying to develop products, we just haven't been able to develop something that is self-sustaining, at what we felt was an attractive price. Frankly, I am leery about guaranteed benefits and premiums. I would prefer products with non-guaranteed premiums, adjustable premiums, but that's tough, I think, to sell in the market when some companies have attractive products with extensive guarantees in terms of benefits and in terms of premiums. So I guess the result of this is that our agents, in fact, wrote a lot of disability income business. I believe that it is not really all that significant. I don't know if we made the right decisions, but certainly we would prefer to have seen better results from our Major Medical product. I guess based on our results, there hasn't been a stampede of people following in our tracks with Major Medical products. I'm disappointed frankly that we have not been able to develop more attractive viable products in disability income.

MR. CLARK: It was about 2½ years ago that we began one of our periodic reviews of our commitment to individual health insurance, and at that time we had about $15 million in-force of medical expense and perhaps $10 million of disability income. We knew from the outset, because of our large group operation, that we'd have to continue to write group conversions and any decision to stop selling medical expense business would not release us from the responsibility to closely manage the in-force business to avoid losses. A number of possible reasons for continuing to write medical expense business were examined and eventually rejected at that time. Profit expectations ranged from bad to worse depending on who you spoke to. They were all bad, and the chance of reduced demand on scarce data processing and actuarial resources seemed very slim, and that was probably one of the biggest factors in our decision. None of our agencies and very few of our agents were dependent on these products. In total, the medical expense made up about 3% of our commissions for the whole company. It was not an important contributor toward validating new agents. We had felt, or at least some of our people in marketing argued for years, that this product is sold by new agents. It helps them validate. Our study showed that was not true. I think our decision to abandon that market wounded the pride of our home office people (who preached the value of a full product line) more than it hurt the field. We have received very few complaints from our agents or

agency heads, and now we're in a position where we firmly feel that was the right decision. As of January 1, 1979 we stopped writing medical expense business of any kind, except group conversions. As you'd expect, the in-force block is going down pretty fast, and managing that block has been a tough problem. Actually I think we showed a loss this year, but if just one state, Florida, behaved better that would turn the thing around. We have a very large block there and are not able to get the rate increases that we are able to get elsewhere.

We also took a close look at our disability income operation. It was everyone's expectation that we would stay in that market. Neverless some of our top people were critical of the level of expected and actual profits in that line, and especially the rate of return on the operation. When you consider the risk and the required surplus to back up that risk, it was not a comparable rate of return to our other lines of business. That was also a time, you might recall, of recently worsening claim experience both in private and public plans, and concerns about over insurance and liberal benefit provisions were very wide-spread. There was serious consideration given to abandoning DI as well as medical expense. But the decision to stay in was made mainly from a strategic viewpoint. We really felt that we could justify a low rate of return on a fairly small amount of surplus because of the frequent use of this product as a door opener, as a first sale in the professional and business markets, toward which we were all aspiring to aim our agency operation, and that's probably true in many companies. There was also the feeling as Al expressed that this is an insurable risk which insurers like the Lincoln should make a concerted effort to retain for the private insurance industry, and that we ought to go down fighting a little bit harder than that. So we agreed to maintain an aggressive market position, upgrade our product line, and develop whatever products were needed to remain competitive. This meant making some rather minor changes in our non-can product line that we sell to professional and business clients, aimed at the upper income market. We have, I think, a very competitive line in that area but it's very comparable to what many companies sell, and I won't spend any more time talking about that. The big question we faced was what to do about the middle-income, lower income market, for which our non-can products are not suitable. Our experience, like the industry's, with traditional products had become particularly poor and seemed to be worsening. We agreed with some of the astute experts in our business that a major change in product was needed if an operation was to remain viable in that market. We developed a product with which I would assume some of you may be familiar, but on the assumption that some of you are not and would like to know about it, I'll spend a few minutes on the background, the philosophy of this product that we introduced late last year. As background though, let's look at the characteristics of this lower and middle-income market that perhaps, in our case, we think require a different kind of product. First is the relatively large proportion of this income, which may or may not be replaced in the event of disability. That is, Social Security, Worker's compensation programs, are not always paid for every disability. It depends on the facts of the situation, and the traditional choice which faced us with conventional products is either overinsurance or underinsurance which is not a very attractive choice. Second is the relative importance of short term and state disability cash sickness plan benefits in this market, and the role of the unimportance of Group Health/LTD compared to the upper income people. This further complicates designing simple products to match the client's specific needs. Third is the relatively high rates of unemployment and job change resulting in large changes in income and hence large changes in the

amount of needed insurance. I think that's more of a factor in this market than the high income market. And last is the wide variation by state in the level and adequacy of Worker's Compensation Benefits which in some states have become extremely large and liberal. Traditional policies paying fixed amounts of benefits with long term renewal and price guarantees simply didn't seem appropriate. At first we thought we couldn't solve these problems within the existing structure of state laws and regulations. We really felt that the problem required solution by new laws and new regulations, particularly in some of the larger, important states. We decided that it was an important enough problem to have the right product in some states even if it meant having 2 lines of products, one for the states that would approve it and one for the other states. The product that we developed is fairly simple in concept, but the policy form is quite complex compared to traditional policies. Much of the complexity was necessary to maximize our chances of state approval and are really not intrinsic to the design ideas or the product itself. Basic concepts are: first, $1 for $1 reduction for actual government program and Worker's Compensation Benefits. It's a "last to pay" benefit. Second is a pricing structure that recognizes assumed amounts of anticipated government program and Worker's Compensation Benefits. Third, there is a periodic re-determination of the amount of disability benefits and the premium charged, in our case 3 years, with an appropriate reissue at that time. Fourth, amounts of private individual and group benefits are recognized in the amount issued, in a traditional manner, although we do include the relation of insurance to earnings clause. The relation of insurance to earnings clause that has been around for some years isn't very good, but we felt that having it in there would make our case stronger for trying to get states to adopt a more effective clause. So we do have the relation of insurance to earnings clause in our policies. And last, there is a provision in the policy that provides health guaranteed insurability. It gives the right to double the initial amount of benefits so long as the insured purchases at each time of reissue the maximum amount for which the insured qualifies, based upon their income and other insurance at that time.

The actual physical product is a guaranteed renewable base policy with level premiums providing $400 of monthly benefits. Attached to that is a 3 year renewable rider. Every 3 years the rider expires, but it contains certain terms and conditions upon which it can be renewed. The rider must be purchased for at least $100 of benefit. Premiums for the rider are based on attained age rates as you might expect. The premium calculation for the rider is complex, and we now have it computerized at the agency level which we didn't have initially and which was our biggest problem with the product. Layers of assumed amounts of benefits which would be offset by the different combinations of government program benefits are determined and multiplied by the appropriate rate. What that means is there may be 4 rate calculations for the rider for the different bands of benefits that would be offset by different combinations of social insurance benefits; the top band being the amount applied for in excess of the largest government benefit they would receive. In effect, that's full coverage benefit and a regular rate applies to that band. The lower bands have premium rates that are less than a full coverage rate because there is some assumed offset built into the rate. The result is a product that makes, we think, more efficient use of the insured's premium dollars by minimizing the chance of over insurance and by maximizing the guaranteed amount of benefits they'll receive. The result in our case is at the lower income levels (and we go down as low as $8,000 annual income) our participation limit is 70% of

$8,000. That grades down to about 40% at $130,000 income and issue a higher percentage of that income, but the rate of course is fairly low because there is a very high assumed level of offset from Social Security, Worker's Comp. and other benefits. At least the agent is able to sell something and guarantee the buyer 60%-70% of his income.

One of the problems that we've experienced with this product now that we've had it for about a year is the description of the re-underwriting, the reissue process, and the options and consequences of each are spelled out in the policy form. This makes the policy form very complicated. We were afraid that if we didn't do that some of the states would object. I really think you wouldn't have to spell all these options out in the policy form. It could have been done under company rules at the time of reissue. We thought it was better to guarantee these various steps and options, spell them out in very simple layman-type language, but it makes a very long policy form in the rider. The re-underwriting and reissue process itself has to be automated, and this does produce high overhead costs and requires, I think, some additional commission payments at the time of reissue. We do involve the agent if he wants to be involved. We're still 18 months away from starting our first reissue cycle so I can't tell you what kind of experience we're going to have on actually going through a reissue process. We have the various forms drafted, the systems built, but at this point it's strictly hypothetical as to how well it will work. The one big surprise was the insurance department approvals. They're naturally slow on any product these days in some states, but we've had far fewer problems than expected. As I mentioned we were prepared to sell this product maybe in half to two thirds of the states and something else in the other states. It turned out that as of now we're selling the plan in all but 6 states; Connecticut, Georgia, New Jersey, New York, Pennsylvania and Virginia. Kind of an eastern seaboard conspiracy here I think. We do expect approval before long in a couple of those states. I'm fully confident we'll have at least 46 states that will approve this product as designed. We may have to make some modifications in the other 3 states that we're in, and we don't sell in New York.

I think regulators have recognized that this is a product that's good for both the buyer and the company, and that generally they're not taking a strict application interpretation of the uniform policy provisions law which all of us felt could be read to prohibit our offset provision. Nobody yet has come out and said no, the UPPL says you can't do this. The rate calculation did intimidate the agents and it still does. That's why we had developed this in-house in-agency program for preparing proposals and calculating rates on the spot so they won't have to learn how to do it. And since the policy itself only shows 2 rates, one for the base policy and one for the rider, once we solve the problem it will be more like a group health proposal calculation or a pension proposal. They're complicated, but nobody really has to know how its done or other mechanics as long as the agent can interpret what he receives and the buyer can understand what he gets. We hope our sales will be satisfactory. A number of the key states only approved this plan in late summer, early fall, and we did decide to put off any training, any field promotion in a state, until after we had approval. We were afraid that because it is so complex we'd go out and train them, get them all hyped up, and then 6 months later we'd get our approval and would have to go through the process again. So we're getting a very slow start in some of the big states like Texas, that only approved this plan very recently. We're still in the training process. At this time we're writing about one of these policies for every 10 life policies. One can argue that a 2 year re-underwriting, re-

issue time would have been better than 3 years. That would in effect have given us continuous contestability for financial and other insurance data since we do renew the disability from the information given at re-underwriting. However, we chose 3 years because 2 years would have increased the cost of reissue by about 50%.

To make the product simpler and to be certain the concepts were widely accepted by other companies requires 2 changes in state regulations or state laws. I think our success in filing this policy does suggest that insurance departments might support these proposals. The first would allow companies to combine the base policy and rider into one form, and be able to issue a non-can or GR policy which would be fully guaranteed for whatever period they choose to make it. You would have guaranteed the right to renew it, you may or may not have guaranteed premiums, but the benefit amounts would not be guaranteed. As it is now, we have a base policy that is fully guaranteed except for the right to change the premiums, but the rider, which is the bulk of the benefit, is this 3 year renewable term vehicle. The second change would allow for a pro-ration of benefits on a more attractive basis than relation of insurance to earnings clause. That would allow the companies to pro-rate against any individual or group policies which were not revealed at the last underwriting. This would allow us to, at time of claim, pro-rate against coverage that we didn't have knowledge of when the product was last reissued. The longer that we work with this product, discuss it with agents, our field force, regulators, other company people, I think the more convinced we are that the concepts are right. They do require a lot of refinement, a lot of honing, improvement, but I think the basic vehicle, the basic principles are quite sound and in the long run will help Lincoln quite a bit.

MR. FERGUSON: Thank you, Ken. There are similar considerations in both what Ken said and what I said. We have not got together before, so we're hearing each other for the first time. Their decision, like ours, is based in part on the need to provide products for the agency force, to sustain the agents' income. They're also concerned about leaving a gap which otherwise government might fill, and yet we've made really different decisions. Maybe we have a synergistic relationship going here. Their people sell our CHIP product and maybe our people might sell their disability income product except I don't understand how they'd ever get the rates. They can get the rates for CHIP. We'll give them those. They're printed in the book. You say the rates for your disability income combination product are now computerized and available in the agency. But does that mean that the agent can't on the spot give Joe Doe a quote? He has to go back to the office and work something up? Is that a problem?

MR. CLARK: I know what you mean. The way it's set up, it would be pretty hard to make a one interview sale unless the agent had called ahead of time and gathered some facts. Or knew the facts from other interviews on other products.

MR. CUMMING: I have been thinking a little bit about what you've been talking about. Your approach here is somewhat different from Guardian's, and I'll be very interested to see how your sales work out. 1 for 10 ratio in a predominantly life company sounds solid for early results. It sounds like it's doing rather well. The only questions that I had were the complexity of the design which I think is what Alan is talking about, and there is some question in my mind how much money people in this income category

have to spend on the product that they ought to buy as opposed to what they might want to buy. It will be very interesting to see how that does take off.

MR. CLARK: Just one comment. Our long term goal is to move this product up into the higher income markets. I think today it would not capture business away from our non-can line, but the principles really apply to higher income people too. I think if we had some experience in the lower income levels and the idea catches on with our field, our goal would be then to move it - upgrade it.

MR. CUMMING: What would you say is the hook that would capture the market?

MR. CLARK: I don't know yet. That's the goal.

MR. CUMMING: Despite the neutral-sounding title, "Corporate Decision-Making for an Individual Health Line", I think this has to be classed as a controversial panel on a controversial topic, and the controversy surrounds whether you can make money in individual health insurance or not, whether companies ought to be in it. I think we've heard some very noble things. We ought to be in it to keep government out, that kind of thing. That doesn't apply to us, at least now, although it has at times in the past. We are in individual health insurance bacause we believe that we can make money with the line of business, and we did clear a small profit last year. We have a very high business growth now. We don't know where we're going to come out this year. We're under a lot of pressure from growing expenses and managing claim levels, and consumerists pressure for very high and frequently unrealistic minimum product delivery levels. If you compare our product to other products which are available, there are very few products which have a distribution cost less than 50% of the value of the product, and yet we're under pressure; sometimes you hear figures as high as 65-70% as proposed minimal loss ratios and that's a real problem. But getting back on the subject, I think the major issue is this question: "Can individual health be managed profitably?" And the answer has to be yes. There are companies which do it so it can be done. But there are a number of questions. One question is "What is the company's commitment to earning a profit from individual health insurance?" If your goal is to protect your group business and that's where your main emphasis is, then I think it's unlikely that you're going to manage to gather together the expertise needed to make a profit on individual health insurance. It requires a very high degree of hands-on management. Does the company have an adequate, aggressive, entrepreneurial management to run the business? That is very critical to individual health insurance, and I think for those of us in the big major mutual eastern life company that's kind of hard to get together - a really aggressive management team, and it's a little bit unusual to find it. Will the manager be backed in the face of conflict with corporate sacred cows like the American agency system or the corporate planning people or the senior officers who go off to a retreat somewhere? That's a questions that those of you in small companies face as well as we in large companies.

This leads to the 2nd question which sort of permeates all of this: Should our company stay in the business? I think in many companies the management of the individual health line spends as much time addressing the question, whether we would stay in the business, as they do running the business.

Obviously if you're writing paper after paper about whether you should stay in or get out because there's been a change in somebody up the line, you're not going to be able to run the business very effectively, and people get discouraged and they would want to move on, and they don't really have any career security. So I think that's a question that ought to be addressed at a very high corporate level, and the decision implemented and structured in a way so that you're either in or out of the business. If you're half in and half out, I think it's very unlikely that you can ever manage this kind of a business profitably. Individual health is not a business for the faint hearted. You can't avoid controversy. You can't avoid criticism and make a profit in individual health insurance. So I think that has to be recognized in the way you put the business together. That really leads to the organizational question. Is your company willing to place individual health insurance in the organization in a way that gives management freedom to act and to shorten the decision line so that they can speed decision making and the implementation of decisions to respond to the market place, to respond to the economy, to respond to regulatory developments, to be as responsive as you must be in a business that is as volatile and fast moving as this business. I think if the answer is no then it probably would be just as wise to withdraw from the business.

The 3rd issue is can we trust our sales people and customers? I hear that some people believe that there is a moral decline and this applies particularly to the disability business. People are cohabiting, they drink more, they use drugs, all of this type of thing. There's no question that's true, and they feel that this makes it impossible to conduct business with the mutual trust and candor which is required for a sound business development. I think if you come from that perception, if you're pessimistic about where people are, then likely you'll be able to position your product to capture the market share that you'll need or to find the customers who aren't on drugs, who are eager to work so that you can make a profit. So I think that's an issue. You have to examine your conscience and see where you come out on that issue as an institution. There's no question that there are predators out there who are looking to profit from this kind of business, and it's a very tempting kind of business. But there are also people who need the coverage, are willing to pay the premiums, and are eager to return to work when they have a disability, and you can make a profit selling to those people. I think information systems are very important in identifying pocket problems here.

The 4th issue that I've got down here is "How does individual health insurance differ from individual life insurance, and how does that affect profit?" For an individual health operation within a predominantly life company, and I suspect that most people in the room are in that kind of situation, this is an important question because it frequently means that senior management has come through the life insurance business, they understand the life insurance business but you have to educate them in the individual health business. This creates difficulty for the manager. I think the first difference is the tremendous claim volatility from year to year and susceptibility of claim levels to management. Mortality is a much more predictable pricing parameter than individual health insurance morbidity. A 2nd difference is the high proportion of the premium that goes to cover risk, the mortality component of a life insurance cost. A 3rd difference is the high percentage profit and loss potential. The leverage within this business for running up huge losses if you must manage it passively is tremendous. And on the

other side, if you look at some of the health specialty companies, you'll see that the potential for profitability is quite sizable too, larger than most people in the life operation are familiar with. I think the stability of the risk there would naturally lead to that result. So I think that's a fair marketplace result. The replacement issue is quite different for individual health insurance. In certain markets it's largely a replacement business that you're dealing with, and this means that you must stay competitive to protect your book of business. Otherwise your healthy people will be replaced, and you'll see the deterioration of your book of business as the people who can't obtain coverage on more favorable terms elsewhere stay on the book and kind of poison the profitability of that block. The coverage variations are much more elaborate than life insurance. Some people dismiss them as bells and whistles, but frequently if you're out in a sales situation, if somebody's anxiety point is touched by something that is..one person's bells and whistles is another person's claim that got paid that wouldn't otherwise have been paid, and those things do become important in selling and they're very important in product design.

There is something which I say around our company that kind of dramatizes things. One is that it's hard to fake a death, but you can surely fake a backache. The other thing is that if somebody gets $3,000 a month for life, that's like winning the lottery. The temptation here is tremendous, and you have to guard vigilantly and manage very carefully to avoid getting into that kind of situation. So there's a tremendous need for specialized managers who are building their careers in this business, and a company that is only halfheartedly in the business won't be able to build that kind of expertise to address that kind of "winning the lottery" type problem which is a very, very difficult one to address.

In looking at some product issues, I think there are a number of them which tend to confuse the basic picture, and I think the basics are management. The need is for very strong aggressive, knowledgeable, specialized management. Of the product issues which have come up, one is the over-insurance question. There are some companies which are very, very aggressive and uniformly make a profit, and don't seem to be as concerned about the over-insurance issue as other companies which aren't so aggressive and do seem to have profitability problems. That means there must be something in there more than just over-insurance. That isn't to dismiss the over-insurance problem. It's just to say that it's not as simple as it's frequently portrayed and it need not be the scarecrow that keeps you away from the business. Another issue is very long "his occupation" periods. A lot of people believe that because of long "his occupation" periods there is gloom and doom and return to the 30's. And yet we do see that there are profits being made. A similar kind of thing is the total disability qualifying period for residual. Northwestern Mutual has a 0 day partial disability benefit. That means you never have to leave your desk to collect benefits. If your doctor says you're suffering from exhaustion and that you should cut down on your hours and that you're, therefore, partially disabled and ought to limit your hours to 4-5 hours a day, if any of you in the room feel that way go buy a contract from Northwestern Mutual because you can put in a claim. Frankly I don't know how they manage it, but they do seem to be managing it now, and their results seem to be coming in all right. So even something that seems as wide open as that, there must be a way of handling it. In the medical care area, some of the issues are the comprehensiveness of coverage and the issue of rate increases.

I'd like to make just a few quick observations on some fundamental management problems. I guess that's what I've seen talked about here. The first problem we're confronting right now is to increase our revenues faster than our costs in an inflation-driven economy. That I see as my most important task. This is not a problem which is unique to individual health insurance. Life, too, has this problem, and I think given continuing high rates of inflation the dynamics of the market-place inevitably and inexorably will drive life insurance toward lower premium types of coverage. As people try to escape some of the tax of inflation, they become more sophisticated in viewing the savings element in life insurance. They go to more non-par type coverage, lower priced products generally. If that continues to move, I think it will push life insurance toward more of an individual health-type mode. If you get into a very heavily term insurance operation, then the life insurance operation becomes much more like a casualty business, and a lot of the kinds of problems which were confronting individual health insurance carry over into life insurance. In fact health may wind up being in a better position, at least from my perspective. I hope it does because it helps us. We lack this problem of the savings element, which is a big one that life actuaries really have to address and deal with. Inflation increases the need for our products in a way that the public accepts. The need for increased life insurance in the face of inflation has to be sold, and when you're paying high front-end costs for business and you have to pay high front-end costs to agents for the inflation-driven increment of the business, you get into problems in an on-going inflationary economy. So I think that helps us in health. The other piece is that the morbidity component of our premium is staying high because it is inflation-driven while the mortality component in the life insurance premium is dropping. So all of that will help us to deal with inflation. I think individual health may come out of this period in a stronger position relative to life than it has in the past, even though it might at first blush look the other way.

The 2nd problem for a life company, or for an individual health operation within a life company, is gaining recognition of the quick response character of the individual health business and its fluctuating results. You get into a feast or famine attitude by success of generations of life-trained managers, and this is really an education problem for the individual health management. They have to get in there quickly and alert new generations of management to the special character of the business. There's the need to manage rather than to passively administer claims. That's very, very important. It gets back to this lottery thing. You have to have some kind of an information system that provides feedback from claims to your sales and market focus so that you're focusing on profitable segments of business, so that you weed out problem agents or customer blocks because it's very easy to be set up in an individual health insurance business, and you've got to be right on top of the business. You've got a very close liaison among your claims people, your underwriters and the field management people.

Then there's a need to recognize the consumer's influence and the heavily regulated character of the business, and there I think it's essential to maintain good credibility with the states and to be active in the HIAA. I think companies which aren't active in the HIAA are missing out on a lot.

There's a need to maintain either a competitive edge to hold onto your book of business in the face of the replacement problem or to maintain a market-differentiated product portfolio. One or the other. Otherwise you tend to get your portfolio pruned by your competitors as they skim off the better

business from you.

And the last problem is how to educate and persuade your sales representatives to prospect in your more profitable markets. You've got a number of things. You shouldn't overlook any of the tools that you've got to focus your sales representatives where you want them to be. Compensation, sending out information to the field, jawboning, getting on the phone with managers and generally being tough. Individual health insurance can be profitably managed, but it requires a tremendous commitment.

Alan has addressed the first question. The next question on the agenda was how do companies decide which product lines they will market? We have two product lines, a high deductible Major Medical product which we've offered since 1962, and a disability income line of business which we've offered since 1961. I think we recognize more the need to make a profit or we're going to be in a lot of trouble. The Major Medical product that we now offer was a very forward-looking product when it was originally introduced, and we have kept it up to date over the years. We don't have inside limits for example. It's not as comprehensive as CHIP, but it does meet a very real need in the individual health area. It is guaranteed renewable for lifetime. It supplements Medicare after age 65 on a full basis. It's not a Medicare supplement. It goes by a true reasonable and customary rather than what HEW promulgates as the current standard. We've continued to offer it and to expand our sales of it because we make a profit with that product, and we make a substantial profit in some years. We did build up a deficit through the 60's, but in the 70's we've consistently made a profit in every year except one, and we've now reduced the deficit to about half the size that it was in 1971. In pricing an individual health insurance, we use the Anderson method with a return on investment, and we try to recognize what the providers of our capital could get from other investments plus a risk premium. Right now we're using 25% to discount future profits in our current pricing.

In the disability income area we had an unprofitable line. In 1973 we did an analysis of our sources of profit and loss by market segment, and we discovered there were very large profit margins in the professional and executive market. We analyzed what was needed to establish a position in that market and we entered very aggressively into it. Our sales have grown consistently thereafter, perhaps not as rapidly as they would have grown if we actively sought brokerage business, but we are a career agency company. We have won back most of our agents who were brokering with Provident, Paul Revere and Union Mutual, and that's been encouraging for us. That business is now clearly profitable on a GAAP basis, and its still growing very rapidly so we're still encountering business strain there.

MR. FERGUSON: I think maybe you should have acted as moderator on this panel. You could have started off with your peroration and then gone on to what each of us were doing in the market. The next question which, in fact, has already been touched on, is the factor of profitability. Ken, do you have a comment?

MR. CLARK: I just want to echo and elaborate on a few of the comments that were made. The wide fluctuation in experience that you get on this kind of product compared to life insurance, per dollar of in-force premium, does cause some problems. Our management, especially our senior management, today is extremely concerned with and focuses on short term results.

It used to be we did an annual statement and that was it, but now with the quarterly report and the emphasis it gets we spend an awful lot of time explaining why our losses went up 100,000 or down 100,000. There is tremendous emphasis on short term financial results within a large life company, where they expect very small deviations in earnings in the other product lines. It does cause a problem to be in this business. Secondly, because of this fluctuating type of experience, we're required to set up a much larger amount of surplus in back of this business which has to have its yield upgraded for inflation. We need to make our step rate products more viable. People put a heavier time value of money on their premiums. Perhaps we'll see more step rate greater premium products in disability insurance the same as we're seeing in life insurance. I think the automatic roll-on or increase type benefits like we have in our GI benefit are going to become more prominent, the acquisition costs being what they are, and the need for the agent to build up a base of clients to produce more and more income. We're seeing in the life insurance field the popularity of CPI riders, automatic increase type benefits as a steady source of additional revenue. I think that can be brought over into disability income with the same results.

MR. CUMMING: I just agree with what he says. I think we probably will have more step-rated contracts. We have a bit of a persistence problem in doing that, which is why we're not going that route right now.

MR. FERGUSON: I've got one comment I would make on what you said, Jack. You emphasized the need for aggressive management, tough decisions, before a company should decide to engage in the health insurance business. I think it's a little pious because I think every company would think it is hard headed, aggressive and it can do whatever it wants to. On specific problems with the profitability of a health insurance line, you emphasized the fast response needed, and I think that is a very key element. You do have to monitor your claims, you have to see what is happening with your line. You have to adjust for changes in the market, changes in the economic climate. You've got certainly to get rate increases through promptly. That is getting, in the Major Medical line, to be a more serious problem. We make rate increases every year to keep our products, hopefully, self-sustaining, and more and more we run into problems with states in getting approvals for rate increases which we feel we have adequately justified with the statistics which we developed. We get questions from state insurance departments who just don't believe the figures that we're giving them. You have to, in this business, underwrite both for health and persistency. We don't take individual lives and decide whether this person is going to be persistent enough, but we've developed rules for the class of business that we will consider for Major Medical insurance, and we are trying to avoid the people who are between jobs because we found through experience that if you don't look out, you get an awful lot of people who buy this contract and you get very large lapse rates even with our rules. We get lapse rates around 45% in the first year, and most of it is because people are moving on to jobs where group insurance is available. So we strive to limit our sales to people who have, we hope, a long term need for the product. Our commission structure should probably not be the way it is. We have a heavy front-end load, 25% first year commission, and in retrospect, with the experience that we've had in persistency, that's probably too high. A more leveled-out commission system would have been preferable. We have, as I said before, developed in the last 2 years a temporary product which we hope takes the pressure off selling a long term product. We, therefore, have the thing which we call TEMP which is a 3-6 month product.

It's important to recognize promptly variations in rates by area, by plan, by sex, by all the factors which enter into it and make appropriate adjustments. It isn't easy. You feel at times you're walking up and down an escalator. I suspect that really the problems in this line are going to get worse in the future because health care costs seem to be escalating at a faster and faster rate. We are unable to distinguish between the elements that contribute to that, whether it's high utilization or inflation in health care costs. I guess one thing that we have with our product having had it in effect for a number of years is the wearing off of selection. You do get the ones who tend to keep the product, and particularly the ones who keep the product even though they now have Group Health Insurance. These are the ones who are benefiting from it. One interesting thing that Jack mentioned was the need. When you're talking about the need for a fast response and for a concentration on this product, I believe that you in the disability line have concentrated your administration of the product in one area despite the fact that you, like we, are a decentralized company. It may well be, particularly with disability insurance, that the need for skills in underwriting and selecting risks for this product is such that you can't spread it around. You've got to have people who concentrate on disability insurance instead of doing both life and disability. We have, so far at least, in some of our operations, totally decentralized both life and health. They are handled in each of our Home Office operations.

MR. CUMMING: What you said about the question of decentralization is a very sensitive business. If there's a pin prick in one part, you've got to know it instantly, at the core, so you can act to get the pin removed. It's hard for me to conceive of how that could be done in a decentralized operation. As I understand it, you have the underwriting in your regional offices. I would think that would be very difficult for you to manage from Newark. If I understand it, your position is how do you function with the regions if you perceive a problem? Do you have to act by persuasion or do you have the authority to move in and make changes quickly?

MR. FERGUSON: I think we have the authority to move in and make changes quickly. The problem is having and developing the expertise which I think is essential. As you pointed out, it is different with health insurance, in particular disability income, than it is with life insurance. So if you're going to develop an expertise it seems sensible to concentrate it. I guess that's what you've done.

MR. CUMMING: That's correct. An example of why you need to have it centralized is the underwriting manager. If you've got your underwriters all together the underwriting manager can come out and say "I feel uneasy" about such and such a category. One recently was Iranian bakers in Chicago. "I feel uneasy about Iranian bakers in Chicago. I'd like to see a re-application on them." Now 9 out of 10 of those won't factor out to be a problem. It's just for some reason the instincts of the underwriting manager are aroused and he feels a little bit uneasy, and he gets comforted when he's looked at the business. But it happened that we did write 13 Iranian bakers in Chicago, and now 6 months later 12 of them are on claim. You get that kind of a pocket in individual health which I think you don't really encounter in life insurance. If you wrote a group of 13 it would be unlikely you'd have 12 deaths within 6 months for some reason.

MR. FERGUSON: I think that we on the panel have used up most of our ammunition. I see a lot of people in the audience from companies who are involved in the health insurance business. I invite you to make statements, ask questions whatever you wish.

MR. PAUL BARNHART: I have a couple of questions, but first I wanted to ask Ken. Ken, when you were giving the list of states that hadn't approved your disability rider I was confidently expecting California to be among those.

MR. CLARK: California gave us no trouble at all. Actually we up-front made a decision. We had two ways to go. One was just to file the form with the usual 2 sentence statement, "here's the policy" and not explain it. We decided not to go that route, and we wrote a long cover letter explaining the product. So we called attention, if they read our letter, to all the intricacies of it, and they approved it.

MR. BARNHART: And the rider, if I understood you, involves direct dollar offset against Social Security benefits?

MR. CLARK: And Workmen's Comp and state cash sickness.

MR. BARNHART: The reason I bring this up is on behalf of a couple of clients who have been trying to get something in California involving that concept, and just get persistently turned down. I've done that same thing. I sent them a long covering letter and they come back and say what you filed, in our opinion, is discriminatory.

MR. CLARK: That's right. We argued in our cover letter that ours is not discriminatory because every 3 years we do re-evaluate the situation and adjust the price. Our cover letter explained the rationale for the renewability and how that introduced a fairness equity back into what could be an inequitable pricing.

MR. BARNHART: Maybe that's the key, because we can't get any explanation from them as to why they regard it as discriminatory. They simply disapproved and we sent them a long 7-8 page reasoned argument on the issue. They simply said it's discriminatory - try submitting something else. I was amazed that you had been able to get that through California.

MR. CLARK: And we also argued that the base policy, which is only $400, although it is long term guaranteed, in effect it's all pay, no pay because the base came out so small that it's totally offset. In fact that becomes an all-pay or no-pay even though it is dollar for dollar also because the amount is so small.

MR. JAMES OLSEN: I'd like to make some comments on our CHIP product. As you know, we've had some financial problems there. We first started selling CHIP in 1973 and it was a kind of product that was very saleable. Every year thereafter we sold about 50-100% more than the previous year. Certainly that in itself caused a drain on surplus, the acquisition expenses. But we did make model office calculations which indicated that when we reached a plateau and we had about the same number of sales each year that we would be coming into the black. I think that the real problem that we now have is the allowances for trend under COWPS. I think if it weren't for that, we would probably be moving along at a nice rate. So you may want to make some comments about the COWPS.

MR. FERGUSON: Jack accused us of having noble motives. We're willing to rise above those noble motives. We would like to make a profit. We did and we continue to make model office calculations. We had expected to have several years of deficit because of the new business strain. I mentioned we have a high first year commission. This year we have been experiencing trends far greater than what we have assumed. Of course we were restricted in what we could use in those strain factors because of COWPS. We've noticed this throughout our business that we are experiencing very high rates of trend. It takes time for us to react to it because we provide a one year guarantee with our rates. Once the policy is re-rated its rates are good for a year. I don't see where it would be practical to do anything else. This means we have so far only changed our rates once a year. We've made a practice of changing our rates on March 1. So what happens is that we set our rates for March 1, 1980, some time back in November, 1979; those rates are good until February, 1982, because they're going to be still in effect on policies which are written or re-rated in February, 1981, and they will continue for 12 months after that. So you do have a serious problem in projecting out into the future, and if you projected wrong or if you've been restricted by COWPS to use a factor which turns out is inadequate then you're going to have problems. Do you have the same kind of problem, Jack?

MR. CUMMING: No, that has not been a significant constraint for us. I'm not sure why. Wouldn't you encounter the same problem with your group business using comparable amounts of money?

MR. FERGUSON: In the group business you can respond much more quickly. We have changed our rates 3 times this year. How often do you change your rates on your individual product?

MR. CUMMING: We had been on a biennial cycle. We're now going to an annual cycle because of the rates of inflation. We are putting through a rate increase now, and we plan to review the rates every year. That hasn't been a real problem for us. The New York Department is also encouraging companies to come in for rate increases on an annual basis, which is a shift in their position but really reflects the high rates of inflation. People will accept it more readily on that basis, and people are getting accustomed to seeing their incomes go up every year and all their costs go up.

MR. FERGUSON: Frankly, I don't understand how you can maintain a viable business by having biennial rate increases. I don't see any reason why anyone else is not experiencing this. In fact I know that some companies in the small group business are experiencing rates of trend of health care increases that are at least equal to ours.

MR. CUMMING: I think I can tell you. There's a difference in product. Ours is the supplemental Major Medical product. We have a variable deductible product which means that we pay after other coverage. Inflation increases the payments from other coverage and reduces our trend quite a bit, which helps us. So we do not get the same kind of trend as you all get. I think that ought to enable us to hold onto the healthly business because by holding down the rate increases we don't force re-examination of the retention of the coverage. So our business had tended to persist better than others. We did have a problem. We had delayed rate increase for a period, and we put through a 40% rate increase a year ago, and that has driven business off the books which caused us a problem. We are now trying to get back onto a cycle of more modest increases so we can hold the healthy business

in. Those are the people you lose. They'll go without coverage or whatever.

MR. FERGUSON: So you write this business on top of existing coverage.

MR. CUMMING: Yes. Frequently on top of Blue Cross/Blue Shield.

MR. FERGUSON: We don't.

MR. CLARK: What percent of that business is not written on top of other coverage? Do you have any idea of what percent of claims don't involve any offset?

MR. CUMMING: A very small percent of claims. Fewer than 5%.

MR. FERGUSON: I might say that our claim people shudder whenever they hear of fluctuating deductibles and finding out what other benefits are paid from other sources.

MR. CUMMING: Claim people always get alarmed at any new product, until they get used to it.

MR. FERGUSON: Any other comments?

MR. BARNHART: I wanted to bring up one problem that I feel is a very serious and long term and increasingly difficult problem that I feel the industry is not really facing up to very well. I think it also relates to the subject of this session about corporate decisions on dealing with individual health, profitability, etc. This has to do with the trend in state regulation of loss ratios and rate increases, etc. It's my view that we're witnessing a massive breach of contract, if you will, on the part of the regulators. I don't think the industry has really responded to this or really recognized it for the deepseated problem that I think it really is. Let me explain what I'm talking about by just illustrating a couple of things. Let's say a company 5 years ago filed a form in the various states anticipating a 50% present value loss ratio on the product. Now it goes in for a rate increase and it may find that a certain state is saying "we won't consider any rate relief unless your cumulative past experience loss ratio to date is at least 60%." In other words the product was filed in a state, stating the anticipated loss ratio is 50% and that's the basis on which you are filing these rates. In effect the regulator is saying this is acceptable and agreeable to us that you file a product anticipating 50% loss ratio. Then you come back in later for a rate adjustment and find they are applying, retroactively, a different standard. I think there's a need of recognizing, you might think of it in other terminology, but to me I think there's a need of recognizing this concept of a contract with the regulatory authorities. They've accepted something on certain terms and later when you try to get rate relief you find that retroactively a different, higher, inconsistent standard is being observed by a certain insurance department. The current NAIC guidelines for rate increases, which I believe emanated from one of the HIAA committees actually recognize this concept applying retroactively a new and inconsistent standard even to business issued 10 years in the past for example. I guess I find this astonishing that there doesn't seem to be more of a common front, if you will, on the part of the industry in dealing with inconsistent retroactive changes in the guidelines being followed by the regulatory authorities. I think this is one of the major reasons why a considerable number of companies have given up

and withdrawn from individual health. They just find the regulatory climate impossible. There are lots of illustrations of this. For example I recently worked with a client who is trying to file a rate increase in Florida. Recently when you file a new rate in Florida they want a statement that you expect the rates to remain adequate for at least a year.

MR. CUMMING: Kind of a random example, yes. They now want you to file a statement saying you expect the rates to be adequate for 2 years, and I'm finding now that if you come in for a rate increase on a form that was filed before they required that statement, they're trying to retroactively apply this to your rule. Again, kind of a breach of contract in relation to the terms under which your filing was accepted and approved by the state some time in the past. To me this is an increasingly serious and chaotic kind of a problem. I just wanted to voice my view on it, and I'd be very interested in any comment about this area that anyone would care to give.

MR. FERGUSON: I think this is a subject which has been given a fair amount of attention recently. The HIAA did develop some guidelines which the NAIC has adopted as model regulations. There is now an effort to modify those and to limit the retroactivity that you referred to. There are some people here who have been quite heavily involved in this and Will Burgess perhaps would like to comment on how we got to where we are.

MR. CUMMING: I guess everybody is involved. Bob Shapland is here and Bill Bluhm might have some thoughts on this too.

MR. WILLIS W. BURGESS: First of all, in regard to the retroactivity in developing the guidelines, certain concepts were developed which, from the standpoint of the industry and the regulators, appeared reasonable. Namely, when a rate increase would be promulgated, the minimum presumed loss ratio standards would apply to experience over the entire life of the policy, past plus future. The intent was for the revised rate to really satisfy the minimum presumed guidelines. There was a caveat put in the guidelines to take care of the experience prior to the effective guideline, and the caveat listed several factors that could and should be taken into consideration by the states in examining the guidelines and in examining whether or not the rates were presumed to be reasonable in relation to benefits. One of them that was put in there after considerable discussion between the industry and the regulators was forms issued prior to the effective date of the guidelines; meaning that any policy issued prior to the effective date of the guidelines a company rightfully has to justify rates to the regulators, and that would be given consideration. Several other factors were given consideration, and there was also a general statement that these were presumed minimum loss ratio standards, and a company, depending upon special consideration, special factors, could justify any rates that produced lower loss ratios than these presumed minimum loss ratio standards. There was the feeling throughout industry and throughout the regulatory area that that particular, specific caveat regarding forms issued prior to the guidelines and the other factors listed and generally stated, would take care of the problem of policies issued prior to the effective date of the guidelines. Now the problem that arises is that individual states, in looking at the guidelines, from the industry standpoint we want the regulators to adopt the guidelines in total. If they take out that exception for forms issued prior to the effective date of the guidelines, they have not adopted the guidelines. They've thrown the whole thing out of kilter and have not adopted the guidelines. So the intent was that this would cover this particular problem. We felt it was a reasonable

approach to take. As Alan pointed out, there's been considerable discussion now within the HIAA individual actuarial subcommittee over the last 2 months. We've come up with alternative wording which would specifically exclude experience prior to the effective date of the guidelines. We are developing a preamble which will attempt to clearly delineate what the entire rationale behind the guidelines is, and we're hoping with these changes this will make the guidelines even better than they were previously. But I honestly feel that the guidelines as originally drafted and approved by the NAIC, if they were approved in the spirit in which they were drafted, was a good compromise between industry and regulatory views.

MR. CLARK: I think what was developed, and I was on that committee with Will and other people, was a compromise that we felt there was a reasonable chance that states would adopt. I think anything we do to make that model bill better for the industry just means that many more states will change it when they adopt it. It's not something that states have to pick up in entirety. They will make their own changes in it. We can't stop that.

MR. FERGUSON: Which is the reason why Paul is disheartened by these developments. Where do we stand as far as states adopting these? I think Utah has. Tennessee is considering it, and I think that's about as far as it's gone so far.

MR. SHAPLAND: Virginia is about ready to do something.

MR. CUMMING: Bill Bluhm, what's the attitude of the New York department toward the NAIC guidelines. Are you familiar with that? Do you want to address Paul's question about a different standard applying when a form is filed and when you come back for a rate revision? Because I think that's where your paper gets into it.

MR. WILLIAM F. BLUHM: The problem has come up with a number of companies. The reason that I can see for what's been happening is that there have been some significant advances in underwriting on the part of the industry and regulators regarding what the proper procedure to use with rate increases is. Probably regulators aren't understanding as quickly as the industry is. Unfortunately that's the nature of what's going on, but a lot of the requirements that New York for example is putting on rate increases didn't exist when the forms were filed because we didn't know they should have existed when the forms were filed. Usually that's the argument that's taken, not what we're doing is incorrect or theoretically wrong, but rather the understanding wasn't there and they weren't filed originally with that thought in mind. We feel a very important aspect of the problem is that insurers should take the responsibility for meeting the anticipated loss ratio that they filed when they file the form. A lot of companies feel that what's in the past is in the past. If prior loss ratios were low, current loss ratios are high and going higher, that because the NAIC type of outlook of combining past with future didn't exist at the time it was filed, at the time it was filed it was based on theoretical assumptions, that that should continue. We shouldn't look back, and that outlook has been raised to us in the same context of saying you're applying things retroactively. I don't think, unless we're forcing a company to take a loss because we're applying new standards, I don't think it should be considered breach of contract or an error in any way if we are applying newly developed theories to derive these rate increases. Regarding the NAIC guidelines, New York is, as you know, in the near future probably going to come out with a revision of Reg. 62 which we

are hoping, we don't know now how much we'll be able to include them, but we're hoping will be able to follow the NAIC guidelines at least in principle.

MR. FERGUSON: I think the problems that exist with this is, as Will mentioned, there are a lot of caveats in conditions and in the language of the guidelines. Unfortunately I think the guidelines are apt to be enforced by states just in terms of those loss ratios. Without consideration being given to various factors such as wearing off of a select period of the mix of business. A lot of those factors may be very relevant to a company's business. What you said about companies anticipated loss ratio bothered me. There may be a standard of 50% as a minimum loss ratio, and a company may say that it expects its loss ratio to be 60%. I hope it doesn't mean that that company has to meet that 60% and cannot ask for a rate increase if its loss ratio is 55% which is above the minimum but less than what it said it thought it was going to achieve. One thing I think is very evident from these guidelines is, it gets back to the comment you made about responsiveness. It is very important that companies make rate increases in a prompt fashion because if you get to a situation where you have got 65% loss ratio then you have losses. You have problems in the future in developing profits to offset those past losses.

MR. BLUHM: I just wanted to say one more thing. There is another loss ratio that's involved here that is generally ignored, and that is the loss ratio that is printed on the disclosure statement that goes to people who own a policy. We feel it is very important that companies live up to that loss ratio. If the minimum in the regulation is 50% and a company files at 60% and prints that out we feel the policyholders have a right to expect their block of business will get 60% return on their money. That's the only major consideration. If a company had come in and filed at 60% just with us and the disclosure statement said 50% we are not going to require 10 years down the road that they use that same 60% if I understood correctly.

MR. CUMMING: I think what we're doing is talking about an issue, and I think what this illustrates for all of you, in answer to Paul's question, that we're involved in a dialogue. It's been 10 years since we've had the anticipated loss ratios calculated on a present value basis. We've never really developed a basis for monitoring how we're tracking to that. I think our eyes have been opened. We know if you're going to have anticipated loss ratios at some point there's going to come a day of reckoning, and you're going to be asked how are you doing relative to what you anticipated? I think that is what is surfacing now. There are a number of issues involved within this. One of them we just talked about, but there are many issues. There is a dialogue taking place within the individual actuarial subcommittee, with the NAIC. These discussions that Will and Spence Koppel, I and others have had with the New York department on a number of different forums, to try to identify what are the theoretical questions. I don't think we've developed all of the mathematics that's involved in monitoring present value type anticipated loss ratios. Then the regulatory questions if we're going to monitor to that kind of a loss ratio what do we do with loss ratios that are in the A&H policy experience exhibit, because they have political force just by the fact that they're published and what do you do with them? What happens if Al Lewis goes down to Washington and is embarrassed in front of the Senate by questioning pulled out of the New York state annual statements. We've got to be prepared to deal with that. So I think all of these things have to be addressed. I think it's just going to be a matter of time until

the thing settles down with something that we're all comfortable with and able to manage our business with.

MR. BARNHART: I just want to say a few other things about this. I think one of the problems is putting some of these problems over into the special justification area. I think a lot of states do tend to simply go by those loss ratios that are published. If you start trying to plead special considerations you're really in trouble. To me, saying that the special consideration is the basis on which you filed the rates in the first place is hardly a special consideration. I agree very much with Bill Bluhm on one point. I think any company should be prepared to live with the basis on which it filed its rates and whatever loss ratio it may be using in the disclosure statement. Certainly the industry should live up to the basis on which rates were filed just as much as the regulators. I think this concept of a contract with the regulators that I've expressed applies to the company every bit as much as to the regulator. I think the companies have to be sincere and honest in living up to the basis on which they themselves have filed.

MR. SHAPLAND: I think there might be some misunderstandings between regulators and insurers about what a loss ratio means. If you file at a 60% loss ratio on a new policy, does that mean that the insurer guarantees that its expenses, even with inflation, will not exceed 40%, or if they do, then they are going to eat the loss? I think it would be very dangerous in its impact on the future profitability of our business to say that we're going to guarantee our expense ratio.

MR. FERGUSON: I think that consideration should be given to expenses. I think others may want to comment on this as a political fact of life. You're not going to be able to right now say that you shouldn't have a 60-55%. It may be unfortunate, but I don't think we can avoid it.

MR. SHAPLAND: That's because regulation, to me, has gone down the wrong track. I think the loss ratio is the wrong way to regulate anything. You don't regulate any industry on the basis of some ratio. Any other industry is regulated on the basis of its total costs, whatever those are. It involves tremendous risk if those expenses are going to be guaranteed. I don't see how companies can issue certain kinds of contracts that don't have claims increasing along with expenses.

MR. BURGESS: The one thing I want to emphasize about those guidelines is the presumptive nature of the loss ratios. The guidelines are designed to be presumptive minimums which means that if a company can demonstrate over the life of the policy that the presumptive minimums will be followed, then a responsible regulator will accept the rates that are filed on that basis. This is designed to help both the industry and the regulators in minimum presumptive standards. Now if the guidelines are accepted in that spirit by the states and adopted per se in their entirety, then I think that the industry and regulators will have come a long way in the rate filing and the rate approval procedures that are followed both by the industry and by the regulators. The attention really is to come up with minimum standards for the presumption of reasonableness of benefits to premiums, and if it's followed in that spirit both by the industry and the regulators then we will have come a long way. So the question is the extent to which the states will deviate from the use of those standards and the extent to which the industry will cooperate in the use of the presumptive minimum anticipated

loss ratios by those standards.

MR. FERGUSON: And the revised preamble I think emphasizes this point, but again it's questionable the message will get across the way that we hope it should be taken. Does all this conversation on the problems of loss ratios and state regulation further discourage anyone from getting into the individual health business? Does anyone else wish to make any comments?

MR. CHARLES GREELEY: I'm really quite ignorant in the health insurance area so my question is more general in nature. I'm interested in the corporate decision making process, the planning process at Prudential. I hear you say you're not going into disability income too aggressively because you don't want to lose money. And yet you recognize you've lost money on the CHIP policy, tens of millions of dollars over the last few years for possibly a good and expected reason which is expected to go away with the passage of time. Now other factors have come into play which you did not anticipate. You're going to lose some more money now and may lose more money in the next few years. I'm curious how your corporate management works. Do they make a 5 year plan for the CHIP policy? You may lose $50 million more over the next 5 years. If that happens they will not torture you annually to explain to them why you're losing that much money? Or do they expect you to come out even for the next 5 years? I'm just giving hypothetical examples, in which case they leave you alone. Or do you go through an agonizing reappraisal with your top management year after year because this is losing a lot of money. Do you have a discontinuity problem in the sense that your management as you mentioned doesn't let you alone to do things, but questions you closely each year because this is a loser? How does your management at Prudential permit you to work in this line? Do you have goals which if you meet they leave you alone? If you do not meet the goals each year how does the process of a losing line like the CHIP policy work at Prudential?

MR. FERGUSON: We look at all our small group business as a whole. We have made projections which show that we will be in the black. As long as we can demonstrate that on a reasonable basis, they leave us alone. I really can't give you a very satisfactory answer to your question. There is certainly concern and disappointment over the results that we will achieve this year because it looked a couple of years ago that the thing was delayed but coming into the black in the way we had anticipated. There has not been any discussion about re-evaluation of our position, that we should change course now because of these external factors which have been impacted on us, to cut back. Let's withdraw from this business. In fact, we filed for relief from the COWPS guidelines, and we expect to, next year when we come around to our next set of rate increases, to have rates that we believe will be adequate. We'll further defer the time which we wipe out our deficit, but we think that the business can, in the long term, be conducted on a viable basis.

MR. BARNHART: You had mentioned that this year it was the high inflation rate that was causing 1980 problems.

MR. FERGUSON: I think it's a high increase in health care costs. I don't think it is just inflation.

MR. BARNHART: You also mentioned that part of the difficulty had been again in the regulatory area. I wonder if you could comment on the extent to which your losses have been due to regulatory delays. I gather some of

that was maybe simply delay in getting rate approvals beyond your March 1 target date.

MR. FERGUSON: I think the last one we got for rates to be effective in March was in fact August. That was just in one state. Other states have been one month, 2 months delayed. I couldn't give you a figure actually of what amount of additional premium we have lost because we were not able to put through the rate increases on a timely basis. Not too much because it has tended, fortunately, that the major states have been pretty prompt in their acceptance of our rate filings.

MR. BARNHART: So by and large delays by states have been a relatively minor factor in total loss picture.