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DIRECT RESPONSE MARKETING TO SENIOR CITIZENS

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- Marketing opportunities
- Marketing techniques
- Product selection and design

MR. H. NEIL LUND: The senior citizen market is large and growing in this country. It has in excess of 26 million people. These people are readily identifiable and reachable through direct response techniques. Our panel will be addressing marketing, product, and technical aspects of reaching this market.

MR. DONALD M. SCEALS: To understand direct response marketing to the senior age group you have to understand some of the basics of direct marketing. You have to follow the basics of the business whether you are marketing a product that is age sensitive or one that is not. The only real difference is that you are working with a different target. There are four basics: (1) Product--what the people want to buy, (2) Offer--how they want to buy it, (3) List--who wants to buy it or who you can sell it to, and (4) Sell--how you sell it. Some would add timing to this. Timing often becomes confused with time of year.

Timing is more related to your list. The people who are most productive are usually the people to whom you mail based upon when they appeared on the list.

The product is basically benefits, deductibles, and other variables that may make a difference in the price itself. Price sensitivity is still a key to response. People buy based upon perceived value. We don't have the luxury in the insurance business of testing price. We can't

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sell into pots and pans, testing price out at $19.95 versus $29.95 for exactly the same product. The main thing to learn regarding product is what people want to buy.

Within the offer you have a lot of things that you can do. You may want to offer a choice of deductibles. How do you want policyholders to pay? Do you offer an annual, semiannual, quarterly, or monthly basis? Do you give them the chance to charge it to a credit card? Do you give them a chance to have it deducted from their checking account? Is it a single money offer? Do you have a deviated premium? All of these are choices that you can test. Testing is the key to this business because everything in this business is measured. Maybe you want to offer a free premium such as a booklet, a pin, or some other gift item. This can cause a variation in response. A lot of people in this business will probably say that they combine offer and product. I like to separate them because there is a distinction between what you're selling and how you're selling it.

The list is probably the most critical element of all. Who are you selling to? I don't care how good your product is or how good your offer is, if you try to sell it to the wrong people, it's not going to work. Your best list is your own list. Think about that for a minute. Probably within your own company, you have several lists available for selling. First you have your policyowners. Second, you have people who have inquired. Third, you have people who have lapsed. All of these are good lists to work with. You hear a lot in this business about add-ons and cross-sells. The people who buy one product get the chance to enhance it through riders or other forms. The person who buys one product is more prone to buy another product. This is true in any business. Your own list is your most important property. Marketing to your house files will result in responses that are 10, 20, 30, and on up, times what you would get on the open market. Those people have raised their hand, have bought something from you, and have responded to you.

Obviously, it's difficult to live on only your house files. You've got to find a way to get new names in, to build your opportunities for cross-selling and add-on. This is why companies spend money renting lists. In the list rental business there are two basic kinds of lists. One is the compiled list which is composed of auto registrations, telephone owners, or other kinds of reasons for being on a mailing list. Maybe they sent in a warranty card or are voters. Most of the compiled lists are very large, but they lack one key element. They don't have a proven history of responding to mail or to anything. They are just there because of where they live, how they live, or something like that. The second type of list that is available is what we call the mail responsive list. It could be from catalogs, record club files, sweepstakes entries, and so on. These are people who have identified that they open and respond to mail, or maybe it's a television offer they've responded to. So the key psychographic in mail response is that they are responsive. But these lists are small. There are about 25,000 mailing lists that you can choose from in this business. Probably only about 500 of them are worth working with. It's less than that when you think about the senior citizen. Age is not usually an important

factor to the people who are doing the selling. So what happens is that you often don't have age identification to work with.

So what's happening in this business today? Compiled lists are now, thanks to the technology of today's computer, putting mail responsive files over their names to identify those people who have a mail responsiveness. On the other side of the business, the mail responsive lists are merging with some compiled files that have age identification. Within mail responsive files there are four key elements:

1. Recency. How recent did somebody buy something? We're talking about getting to those people who have a more recent purchase. This is true with house files. The person who lapsed five years ago is not going to be as responsive as the person who has lapsed in the last year.

2. Frequency. The person who traditionally buys by mail, not just recently but has a history of buying by mail, is more responsive than the person who doesn't respond frequently.

3. Amount of the purchase. It's difficult to sell a product for which you're asking $50.00 to people who are on a mailing list whose average amount of purchase is $4.98.

4. Type of product. What did they buy? Again, is that product related to your product? The closer identified the product is, probably the more responsive the list which bought that product is.

Let's go back a minute and think about what else is happening. We talked about how the age is becoming identified through overlays on mail responsive files, so that you can identify the most recent buyer by age or the most frequent buyer by age. Within the last two years there has been much development in this area. The cost is coming down for doing this as a result of faster computer processing. Finding the senior citizen is still a problem. What many companies are doing is using television. With television you still wind up selling by mail, because you're going to send that person a mailing package. Essentially you're developing a mailing list. You're going to keep that list and use it over and over again. If it's a Medicare Supplement advertisement, those people who are 65 and over respond, and they form one of your house files. It's interesting that you are using television to hit only one segment of the market. It's like using a sledge hammer to kill a fly. But it works. Strangely enough I don't see a lot of television advertising for the product that is not age sensitive.

The last area is the mailing package itself. Printing presses, design capabilities, and methods of producing materials have been revolutionized during the last several years thanks to the computer. You're seeing a lot of E-tip imaging, laser printing, big personalized letters, personalized names, and plastic cards--all things that you can design in the mailing package to make it attractive. No matter how good your list, product, and offer are, you still have to sell it. This isn't a walk-in business. I don't think insurance ever was a walk-in business.

So the copywriting is an important feature. You're seeing everything from seals to plastic cards. Everything that can get people to open, read, and reply.

The basics of this business require one thing. You measure everything that you do. Direct mail is an expensive way of marketing. Just remember, you're spending all of your money up front. So there is continuing testing going on in this business. We're testing products. We're testing offers. We're testing lists. We're testing our mailing packages, all the time. It is a constant testing and development process. As you're developing your market, you continue to test, and you measure everything. In fact I have a rule: if it can't be measured, don't do it. If you can't measure it, you don't know how cost effective it is. Testing a product, offer, list and mailing package is the key to this business, whether you're talking about senior age business or all response business.

MR. ROBERT J. POLILLI: The four major products used in direct response marketing to senior citizens are:

1. Medicare Supplement

2. Graded Benefit Life

3. Graded Benefit Term

4. Hospital Indemnity

Medicare Supplement has been what I consider the lead product in the marketplace over the last five years. Its future is less clear now due to its competitive posture against health maintenance organizations (HMOs), preferred provider organizations (PPOs), and the Blue Cross-Blue Shields. However, so far direct response marketing has been able to penetrate the market in a mass way.

In about 1980, the Baucus Amendment was passed by the United States Congress. The amendment, named for the Congressman who proposed it, required states to enact laws that were at least as stringent as the Baucus Amendment. If a state did not do this, the Baucus Amendment would become active in that state. So it portended that there would be federal intervention in the states. All states quickly enacted laws as stringent as the Baucus Amendment and, in some situations, the laws were more stringent. The amendment addressed some abuses in the Medicare Supplement marketplace (direct response and agent-sold). One requirement is that the company cannot issue a second Medicare Supplement policy to a person who already has a policy. In the market, there were many situations where people would stack many policies together, of course, to the detriment of the older person. The amendment also proposed loss ratio requirements and specified minimum benefits that had to be in every policy. The minimum benefits came from the NAIC models.

Direct response has used the group trust approach in the marketplace. This provides uniformity. It will get you in about 35 states at one

time. So for a mailing, you have one policy in all the 35 states. For the other states, you would have to use individual policies anyway, but you would have a group in situs in one state and then have basically one product and one offering in all 35 states. The Baucus Amendment, by being adopted in all states, basically creates a situation where there is much more compliance to the individual laws of states, because as you are mailing into that state, the basic law is the same for individual policies as the one of your state of situs. So there is much more uniformity now in the requirements than there was before the Baucus Amendment.

The Baucus Amendment specified minimum loss ratios. Here, there was one special provision that differentiated direct response groups from employer-employee groups. This was important in the direct response marketing. Individual policies required a 60 percent loss ratio. Group policies required a 75 percent loss ratio, but group policies mass marketed as individual were permitted a 60 percent loss ratio. This allowed continuation of the trusteed type of group approach. If direct response had had to comply with the 75 percent loss ratio, there would not have been enough left in the premium to cover all of the expenses.

The usual thing about Medicare Supplement in the direct response marketplace is new and higher premium levels. When we developed our first Medicare Supplement policy, it appeared that direct response marketing had a cap of $20 a month. In developing the first products, we thought it was important to keep under that cap. But because of the higher deductibles since then, the premium has had to rise, and now we are approaching $30 a month. But in the meantime, we found that for a Medicare Supplement product we could sell more than $20 a month. The question now is about going over the $30 a month barrier. It might be like the sound barrier. There was no barrier, just the concern that one might exist.

I'd like to mention the different offer types. In many of these products the initial offer is either a send-no-money offer or a deviated premium of a dollar for the first month. In the send-no-money offer, coverage does not begin, but the applicant may send in the application without money. After the certificate is issued, twenty-one days is provided to pay the premium to activate coverage. For dollar deviated, however, coverage begins with the dollar for that first month. You have to watch your persistency reading and know your systems well. If you collect an annual premium at the end of the second month, it may be possible that it never lapses in the first year. You need to track your persistency of the two blocks separately. Some companies still like to require a full premium. Response rates, of course, are cut substantially, but you don't have to deal with as many policies. In the send-no-money or deviated offers, you loose 30 to 40 percent who will not renew. But you had to go to the expense of issuing the policies. So you can cut down that expense by using the full premium approach.

There is no requirement that a Medicare Supplement policy cover the Part A deductible, the initial dollars going into the hospital. Part A of Medicare covers hospital room and board costs and other hospital expenses. The insured is required to pay the first $492 in the hospital

in 1986. Medicare will pick up costs thereafter for the first sixty days. This $492 is an expensive benefit. The hospitalization rate for this age group is 25 percent in a year. So you are going to have an additional claim cost of about $10 a month. And when you're fighting to stay under a $30 a month premium barrier, this is one of the things that can go from your basic products' offerings. Also in the inhospital benefit, you cover the coinsurances. The largest part of the coinsurance is the point where you pay for 365 days at 90 percent of reasonable and customary charges. This will run into very large claims even though they are very few. My former company had a $300,000 claim due to an equestrian accident. We proposed an equestrian exclusion, but we found that that was not permissible. So you may have some reinsurance needs on these large claims.

Another popular benefit added on to the minimum policy is Skilled Nursing. It runs between $2 to $4 a month depending on the company. However, Medicare's definition of a Skilled Nursing Facility is quite narrow.

The second major area of benefits comes under Part B of Medicare, the supplementary medical insurance program. For Medicare Supplement companies, two benefits of having an insured enrolled in Part B are (1) it makes sense for the customer since it is a government-subsidized program and (2) in the claims department's self-interest, it is easy to use the explanation of benefits in paying the remaining 20 percent of allowable charges.

Medicare determines the allowable charges under Part B, and these are usually less than reasonable and customary. Most products in the direct response marketplace do not cover the excess.

Most products sell at one premium for all insureds. Obviously, this is a terrific bargain to someone age 80 who normally would have to pay a premium twice as great. A few companies use issue age or attained age rates in the marketplace. The advantage of these rates is that the age 65 rate is much lower. One of the prime age segments of the market is the 65 to 69 group. The disadvantage is that your marketing material is more complicated having to describe four or five premium rates. I know of no company in direct response marketing who is using rating by sex with a medicare supplement policy.

One of the challenges of the Baucus requirements is that benefits must relate to the current Medicare deductible and not just the deductibles in effect at the issuance of the policy. The 1986 Part A deductible is $492; the 1985 deductible was $400. Other benefits are stated as fixed percentages of the current Part A deductible of $492: days 61-90 being 50 percent; days 91-150 under the reserve days being 25 percent; and the Skilled Nursing days from days 21-100 being 12.5 percent.

The Health Finance Care Administration (HFCA) computes the Part A deductible following the average trend for hospital cost. So every year on January 1, any Medicare Supplement policy issued will have its benefits increased automatically. I am aware of two different ways companies handle the premium increases needed. One company issues

only monthly policies, and on the policy's due date in January, the premium will be increased since the benefits have been increased. Negatives here are having only monthly policies on the books and the relatively short amount of time from the September 30 announcement of the deductibles to the January 1 implementation. All the marketing material and in-force billing must move quickly up to the new rate. The other approach is to have the rate increase at anniversary, perhaps not even starting with January anniversaries. The negatives here are that rate increases do not coincide with benefit increases. The relationship of the two events in the minds of the policyholders is lost. The actuary must make sure he recognizes that benefits will increase mid-policy year in his pricing calculations.

In order to support a 60 percent loss ratio, the product requires higher response rates than other products being offered by direct response. So far, this has been accomplished.

One of the Baucus requirements limits pre-existing conditions exclusions to those that were treated within the six months prior to issue. These conditions could only be excluded for six months after issue. Some companies are marketing with a three month pre-existing condition exclusion. Nearly all offerings in the direct response marketplace are guaranteed issue so the pre-existing exclusion is standard.

The second product is Graded Benefit Life. This is a whole life product normally issued at ages 45 or 50 up to ages 75 or 80. The purpose is to provide a guaranteed issue product. Due to severe antiselection in the offering, this product normally has a graded benefit period. Many state laws apply limitations on the grading. Some policies pay a return on premium plus interest during the graded period, which is two or three years. Others provide 10, 25, and 50 percent of the face amount during each of the first three years, respectively. The graded period usually only applies to deaths due to sickness; accidental deaths will receive the full face amount. Some critics believe the accidental benefit is misleading. Care must be taken in developing material.

One problem you can "walk into" inadvertently with regard to the graded benefit period is in the federal definition of life insurance. Although these policies aren't designed to be abusive, they may fall outside the calculation. The amount of insurance in the federal calculations can be only the current death benefit. Future increases are ignored. The result can be having maximum cash values under the federal calculation that are lower than the minimum cash values under the Standard Nonforfeiture Law. This situation will require a change in the amounts during the graded period.

The typical design of a graded benefit policy is to have a unit policy; thus, the product is normally sold in units of, for example, $6.95 a month. Typical sales run two to three units on the average.

Some consumer advocates are criticizing the Graded Benefit Life offer. One of the features heavily emphasized in marketing is that the plan is guaranteed acceptance no matter what the state of your health. The criticism is that applicants who could otherwise qualify for standard

issue on an underwritten plan, are paying a surcharge to cover the extra mortality. Thus, they could obtain a better price if they knew, and the senior citizens marketplace requires special protection. New Jersey has passed a law requiring equal emphasis on a companion underwritten life product to the Graded Benefit Life being offered.

The third product used extensively is the Graded Benefit Term. This product has become more popular over the last few years. It is also a unit-based product with level premiums. It is usually a term to age 80. As the insureds enter the next age bands, the amount of insurance decreases.

Often Graded Benefit Term is issued as a group certificate without cash values. Upon application of the Standard Nonforfeiture Law, when this policy is issued as an individual policy, some modest cash values are developed. These values are rarely emphasized in the marketing literature because of their insignificance.

For Graded Benefit Term, the most popular premium units are $1 a week, or else $4 or $5 a month. This plan has become more popular in the marketplace for front-end marketing in the past few years, although it has not totally supplanted the whole life product in policyowner marketing. The initial higher face amounts of the term product are certainly more attractive. However, of course, the term to life comparison is fraught with difficulties here as with standard plans.

The graded benefit feature is more complicated to explain on this product since, not only do the first two years have the graded benefit amount because of the guaranteed issue feature, but the total amount of insurance changes depending on the attained age. A new insured age 58 would enter the next age band before the graded benefit period was over.

The fourth product active in the marketplace is Hospital Indemnity. Hospital Indemnity was the mainstay of direct response marketing in the 1970s, but outside of offers to credit card holders, Hospital Indemnity has been less marketable than previously. Response rates have diminished somewhat, and lapse rates and loss ratios have increased. Morbidity has improved over the most recent years, of course, in line with other developments in the industry. Most Hospital Indemnity policies for age 65 and over have half the daily benefit for the first 60 days. This corresponds roughly to the needs of the insured where Medicare is paying the hospital cost for the first 60 days. But the main purpose is that the cut-back reduces the premium level significantly.

All these products are offered through various media. Graded Benefit Life, Graded Benefit Term, and Medicare Supplement advertisements can be seen on television. All products are issued through direct mail lists. Graded Benefit Life is a popular cross-sell to current policyholders. The success of offering these products to lapsed policyholders can be misleading. Response rates are high, but policyholders who lapsed one policy will also tend to lapse the new policy. In the direct response marketplace, more telephone usage is now done. Telephones

bring on the ability to answer questions so that more complicated products can be brought into the marketplace.

So these are the main products. What can we picture happening in the next few years in the direct response marketing of products? First, let's look at what Medicare does not cover.

Medicare covers about 60 percent of the total medical costs to the age 65 and over population. The first area where Medicare does not provide coverage is nursing home stays other than skilled care following a hospitalization. Medicare's approach here is consistent with Medicare's overall purpose of addressing acute conditions rather than the chronic conditions of the aged. But with the aged population growing older, where perhaps old is being age 80, not just 65, there will be more need for chronic care. So, in addition to covering stays in nonapproved Medicare facilities, intermediate care where stays are much longer is also an area where coverage can be provided. Work is underway to design internal limits so that custodial care could be an insurable coverage.

I'm concerned that the first policies that come out will be "nursing home policies," but may not be what the population expects in the way of a "nursing home policy." Many people will picture nursing home policies as covering the terminal period of life when the person can no longer care for himself. The disability is age-related rather than a specific illness.

The challenge is to design policies that represent insurance and meet the needs of the population. Alternative methods of health care delivery may provide this benefit.

The second area that Medicare does not cover is medical charges in excess of the Medicare allowable charge. The number of provider bills received by Medicare equal to allowable is going up rapidly. It's over 60 percent now, having moved up quickly in the past year. The assignment levels have, however, been frozen for 15 months, so the average ratio of the Medicare allowable charges to reasonable and customary has been dropping. So, even though accepting the assignment is prevalent, the excess medical charges are growing. An excess benefit appears more often in policies for agency-produced business but has not been extremely popular for direct response mainly due to the increased premium level. One question as you enter the market is whether this is really an insurable benefit since the incidence of claims is controllable by the insured through selection of physicians.

Also, can a prescription drug benefit that makes underwriting sense be designed for this market? Although prescription drugs are not covered and can run into large dollar amounts, the question of insurability is serious. Underwriting may make sense but delivery of an underwritten product would be new for the mass market. Perhaps the telephone holds the key to a breakthrough. Other areas that Medicare does not cover are care outside the United States, vision care, hearing aids, dental care, and many at-home benefits.

Outside of the Medicare and health insurance industry, what policies would make sense? First, a guaranteed issue level term policy could be developed so as to avoid customer confusion over the graded benefit period. Second, certificates of deposit (CDs) have certainly been offered by mail, and as we turn ourselves into a financial services industry, this would be more attractive. Third, underwritten term life could be used in this market for some needs. The telephone could be the entrance. However, since it would be underwritten, the challenge to direct response marketing is great. Fourth, the excess interest products that are more competitive in the marketplace (but alas, also complicated) could be utilized.

Obviously, there are many products beyond insurance where direct response marketing is used with senior citizens. Refined techniques and the increased ability to target offerings create opportunities for traditional and nontraditional insurance products.

MR. RAYMOND J. NACIN, JR.: I'd like to spend some time with you discussing some of the basic principles relating to profitably marketing to senior citizens. Some of these principles are basic to any business, some are basic to direct marketing, and some are basic to direct marketing to senior citizens. I will comment briefly on some of the forces of change in the senior citizen marketplace.

The first principle applies to any business. It is to focus your energy, your money, and your people in a well thought out mission statement, plan objective, and key strategy. Have it in writing, reality test it, and use it as a working system. You have to recognize in this plan that older people have special needs and concerns, for example, outliving their assets, grandchildren, Social Security check (when it arrives and when the older people are able to pay their bills), claims form confusion, and losing assets to some catastrophic illness. You have to decide as a company what kind of products you want to provide to senior citizens. There are people out there providing the total needs such as total retirement living including housing, medical costs, insurance, and asset management--anything you can think of that an older person might need.

You might decide that you are going to concentrate on insurance needs. But you also might want to decide to offer accumulation products of various sorts, and you might even want to get into personal lines of property/casualty products.

There are other kinds of products--including retirement counseling, claims counseling, and help with claims forms--that might make any of the insurance products more attractive. You could decide to concentrate on those products that are exclusively commodity products such as Medicare Supplement or guaranteed issue burial life insurance.

Another question in this plan that you have to consider is: Who are senior citizens? Are they people who are 65 and older? Are they retired people, irrespective of age? Do you include people who are of preretirement age, preparing them with products and services for retirement? Do you include the families of retired people? You have to

determine to what degree you are going to build infinity and to what degree you are going to peddle products. The American Association of Retired Persons (AARP) is a perfect example of an organization which has built the infinity, and products are sold as part of that total infinity package.

Another example would be USAA Life Insurance Company which has built the same sort of infinity with officers of the military who are currently out of the military. You need to be sure as you go along week by week, month by month, that your operating plan is consistent with your long-term plan. If it is not, you might want to check your long-term plan and see if it is complete or if there is a gap.

Finally, in terms of the plan itself, you have to realize that changes are taking place in senior citizen marketing. You want to review your plan to be sure it's up to date.

The second principle to profitably market to the senior citizen is that you have to market your product aggressively in order to get the good risks in addition to the bad ones that you automatically get. It also impacts the size of the opportunity. If you don't market aggressively, the absolute dollar payoff won't be as large as it needs to be. You have to realize that today the marketplace may be very competitive, but it's getting increasingly more competitive. This is resulting in narrowing margin and what I would call exotic products in pricing. You need to understand exactly what your customer wants, needs, and will buy. The best way to do this is to ask your current customers and potential customers. You might do that by mail surveys or phone surveys. Older people seem to like to talk to people on the phone. You might use focus groups, research firms, industry studies, government studies, and various other publications to give you input on this.

In marketing aggressively, you have to know what your competitors are doing. If possible, it would be nice to have a copy of their strategic plans, recent statements, and objective strategies. You have to be on top of what products are being offered out there, the positioning, the creativity and the media being used by your competitors. It's nice to know what sales results they are getting with their lists and products. Again, information tends to be very tight in this business, but if you can get any handle on their loss ratios, persistency, and expense levels, this can be helpful. You should have some idea from feedback what their levels of service and performance are. There are some people who are offering this to third party clients, and if that's the case, you should know what the compensation is. Senior citizens are becoming increasingly sophisticated and knowledgeable because of the press, publications, television, and so on. This has been mentioned as a general process of marketing. You need to do some research and test your marketing approach before you roll it out, because it can be very expensive. All the marketing dollars are up-front, and the results may or may not be there.

The third point is that you have to constantly develop, test, and grow new product lines. The time from implementation of a new product might be anywhere from 6 to 24 months. They won't all work, and if

you get one, or two out of five that work, you've probably got a pretty good batting average.

Another point is that, in terms of this life cycle, competitors can duplicate what you've done in 12 months or less. In regard to new products, it's good to think in terms of combinations of existing shelf products. You might have two different products that can be combined or positioned together which will give you something that looks entirely different than what you might have on the shelf. Mr. Polilli has provided an excellent list of core products for direct marketing to senior citizens.

The next point is you have to be careful in formalizing the critical success factors by product line and install an early warning tracking system. These factors would include: Response, how many people per 1,000 respond to your offer; Renewals, of those respondents, how many actually pay a premium; Persistency; Loss ratio; Expenses, the annual premium generated compared to the marketing cost including overhead; Compensation, if you're paying it; and the bottom line by product compared to what you expected. You have to stay on top of each of these factors, if not daily, then on a weekly or monthly basis. As has been mentioned, it's important that, if you're going to make money in this business, you have to do it effectively. To get a handle on the experience, you need that experience by product, by media, by age, by geography, maybe even by zip code. You need to do extensive tracking of your test results. Companies will spend maybe as much as 10 or 15 percent of their total marketing budget on testing. It's important to know what worked, and why it worked, if possible.

The next principle is that you have to manage the business. You can't just do it. In terms of managing the business, there is managing the business up-front and on the back end. On the front-end, there are any number of things you can do. The first one is the preexisting condition--the product won't pay a preexisting illness for anywhere from 3 to 6 to 12 to 24 months. The second thing you can do up-front is decide what kind of a renewability provision you want. Is it guaranteed renewable, is it noncancelable, is it cancelable, or whatever? With a lot of the products, you have a choice of elimination period. Hospital Indemnity might have a 0-day, a 3-day, or whatever day elimination period. But recently, the days of stay in a hospital have been coming down to the extent that increasing that elimination period lessens the consumer value of the product.

Another choice that Mr. Polilli mentioned was graded benefits. You have to be aware of what the mandated benefits and loss ratios are by state. There are any number of states which, for a given product, tell you what benefits to have and what the loss ratios on those benefits are.

Premium level, as I've accounted here, can vary dramatically especially for Medicare Supplement. If you look at the products in the marketplace today you may see products that look like Medicare Supplement products at $12 a month, $18 a month, $30 a month, or an agency-sold

product at $50 to $60 a month. So there is a great deal of price variation in the products that are available in the marketplace.

Benefit amounts offered are important. With increasing inflation, for a Hospital Indemnity product, $30 a month might have been a significant value to a customer five to ten years ago, but now $30 a day in a hospital is not much. You have companies out there that are offering $50, $75, $100 a day.

Also you need to decide up-front the needed response to cover your marketing cost, and you need to determine if possible whether or not that level of response is realistic. With respect to these products, even in the senior citizen age market, you've got the question of, should we underwrite it or should it be guaranteed issue? To the extent you underwrite, you lessen your response, so there is a trade-off there.

You have a lot of flexibility in terms of determining up-front what your marketing cost per 1,000 is going to be. Is it going to be $50 per 1,000, $100, $300, or $400? You have to know up-front that there are some people, probably of all ages but maybe not so much in the older age market, that get involved with fraud and multiple policies. In the older age market, you've got as many people who just want to be sure that their expenses are covered, and they feel that one policy may not do it, so they accumulate, one, two, three, or more policies.

There are bad states and good states to operate in. There are any number of ways to find out which are which. You want to eliminate marketing in the bad states and sell as much as you can in the good states. Always have an option of the collection method. The various options for that have been mentioned. You have some flexibility on how you set your profit objectives be it margin, return on investment, or break-even. There has been some comment already about the future of Medicare Supplement products and the extent that we believe the Medicare Supplement policies won't exist five years down the road. That certainly has impact on your pricing assumptions.

In regard to back-end process, there are a number of things you can do to manage this business profitably. One is rate increases. You have to stay on top of the experience and determine when rate increases are needed and get them made as quickly as possible.

You've got the possibility of alternative offers. If you've got a cancelable product, you can, in fact, cancel the product. In the older age market that might create as much aggravation and problems as anything. One of the big things is to provide input to the front-end management, in terms of what the experience indicates about faulty product design or other things. Claims handling can have an impact on how you manage the block of business. Recognize that on the back-end, when you're trying to correct a block of business, a correction could take anywhere from 6 to 12 to 24 months.

The next basic principle is that you want the block of business to grow. You want to do whatever you can to increase the renewal rate

and improve the persistency. For example, if the renewals are 70 percent and the persistency is 70 percent, you've got 49 percent of those who are responding to the offer left at the end of the first policy year. If the numbers are 70 and 50 percent, you've only got 35 percent of those who responded left at the end of the year. Again, you need the premium to amortize the marketing dollars. If you're involved in compensation, you not only need the premium flow to amortize the marketing cost but also to enable you to pay the compensation. It may also impact the actual level of percentage expenses that you've built into your product. You need to understand that the loss ratio on a closed block of business that isn't growing will deteriorate as the good risks go elsewhere for a better deal.

The next principle is that there is an insurance risk reward trade-off. A number of the products that have been mentioned have a volatile loss ratio. You may have some accidental death and dismemberment products, for example, where the expected loss ratio is 35-40 percent. But you can have tremendous swings in that loss ratio near the end. The problem that you have with the loss ratio swings is that, if they happen in the early years when the premium flow is big on that block, it may be difficult to make it up as the premium flow declines over the years.

Another factor is that a lot of volatility of many of the accident and health products sold to senior citizens is impacted by the economy. It seems that when renewals go south, the persistency goes south, and then the loss ratio goes south.

Another factor is that the loss ratio jumps after any pre-existing condition or graded benefit period wears off, and again on the Baucus Medicare Supplement kind of product. You have to realize that, no matter what your expenses and marketing costs have been, you have to manage to that 60 percent loss ratio.

Another one of these basic principles is that you have to seize major profit opportunities and eliminate the distractions. Spend your time, energy, and money where there is the possibility of big payoffs. Some ideas, even though good ideas, have no real potential to generate large profits. Resources are always limited.

From a pricing point of view, you have to be sure that your pricing is consistent with your forecasting and your financial results. You have to recognize and pay the people in your operations for outstanding results, and you should have a shot at some big bonuses if the results are truly outstanding. The key to making money in direct marketing to senior citizens, or any business for that matter, is to execute consistently a promise which you can deliver. Be sure that as much as possible you've got a production line operation.

In terms of things to watch in the future, there are a number of things that are going on in the health care industry with respect to senior citizens. The first is that there is a continuing growth of the population at ages 65 and over, especially with ages 75 and over where the pricing is more difficult.

There are a lot of changes in healthcare including increased cost due to inflation, expensive technology, and utilization. There is an oversupply of hospital beds leading to increased competition among hospitals and mergers of hospitals. There is increased use of outpatient, outsurgery, and convalescent care to keep people out of the hospital and reduce the cost. There is cost containment such as negotiated payments on the parts of employers and others who are involved in picking up the tab for this care. It appears that we are heading toward a tiered healthcare system, where the people who can't afford healthcare may have a safety net that covers the basic cost that everybody should have covered. But there may be various tiers to the health insurance coverage. I've commented that hospital stays are shorter; they may have dropped one to two days per confinement.

Another change is just the increased competitiveness, especially in the Medicare Supplement marketplace. AARP and the Blues have been there for a long time. I don't know what the numbers are for people covered by the Blues and AARP. I believe 50 to 75 percent of the people who are 65 and older are covered by them. There are all kinds of additional companies getting into the direct marketing to older citizens, especially Medicare Supplement products. You've got HMOs and PPOs getting into that marketplace. Last week on television, I saw an ad that said "HMO/PA: whole benefit coverage and the federal government will pay the premium." So it sounded like it was free. There are a lot of commercials on the air not only from insurance companies but these other organizations. You've got total retirement care facilities. You've got vertically integrated health care providers that provide ambulance, drugs, hospital, and posthospital. You've got third party administrators marketing with employers for postretirement coverage, and you've got a lot of replacement. If somebody gets a policy and the rates go up or some competitor is out there, you find your policy has been replaced by them. Overall, these factors lead to an increased marketing risk.

There are a number of changes coming down the pike in Medicare. There are probably limits on inpatient and physician coverage. There are increases on outpatient benefits, outpatient surgery, convalescence, maybe at some point catastrophic coverage. There also are increases in premium, deductibles, maybe coinsurance, and maybe in qualifying age. We continue to see the impact of diagnostic related groups (DRGs) on hospital cost. We may find ourselves at a point where means tests are required. And there may be other changes that are required for the financial liability of Medicare given the increasing percentage of senior citizens. We also are seeing increasing regulatory constraints and problems.

If you're in this marketplace, you'll find that there are many marketing requirements and limitations. I've mentioned mandated benefits. We also have mandated loss ratios, and on some volatile products, particularly accident products, the loss ratio might be 35 to 40. It could be difficult to meet some of the mandated loss ratios. We've got growth and increased political power of senior citizens that give them a lot more political clout with the states and the federal government than they had before. We have special state regulatory problems including

New York, Vermont, Michigan, Washington, Florida, Texas, and others, and it's probably going to continue to get worse. We can expect, as more people get into the marketplace of direct marketing to senior citizens, that some of the new entrants may get the regulators stirred up even more than they are currently.

I conclude, looking at this marketplace and trying to make money in it, that there are a lot of opportunities for direct marketing to senior citizens. Consistently making money takes a lot of thought; it takes an understanding of basic principles; and it takes constant attention. We all have to be aware of the fact that the marketplace is changing daily.

MR. LUND: We've had a good overview of marketing to senior citizens and direct response in particular. Certain ideas stand out. First, we need to provide a high value to the consumer. Also this business is influenced heavily and modified almost daily by the impact of technological change, inflation, the demographic trends in this country, competition, both from within and outside of the insurance industry, and by regulation and regulatory activities.

MR. MAYNARD T. ROBINSON*: I would be interested in any comments on marketing asset products and/or annuity products directly to senior citizens.

MR. POLILLI: I understand AARP marketed CDs to their senior citizens and put quite a bit of money into their funds. I'm not familiar with marketing outside of that or any annuity marketing that has succeeded well. With the senior market, though we think of them as not having a high income, they do have assets, and so there is a need there. In the future, we would have more opportunity, as the life span is getting longer, and this market, of course, is going to be the fastest growing segment. There is a big opportunity here to design products that become popular in that market.

MR. NACIN: You could go back to direct marketing in general. I don't know of anybody who has been successful in marketing accumulation products. It's probably hard to get somebody to buy a television advertisement in a kit and give you $10,000, $15,000, or $20,000. It may just be the technology. It may be that it's possible, and all we need to do is find out the right position and creative approach. It's something that will be tested and eventually probably will be made to work somewhere. But I don't know of anyone doing it successfully today.

MR. SCOTT LACAZEY**: A comment was made a number of times that the gap between Medicare and reasonable and customary charges has been widening and probably will continue to widen, with the increased

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** Mr. Lacazey, not a member of the Society, is with Casual Life Insurance Company.

competition from HMOs, PPOs, and other providers of healthcare like Humana Corporation which are trying to get into the whole business. Do you see any tendency from direct marketing companies towards getting away from the traditional indemnity type of coverages and heading into a little more of the expense reimbursement type coverages? If you do not see that happening, what do you think the major impediments might be?

MR. POLILLI: A lot of people are looking at HMOs and PPOs and the ways insurance companies and direct response can be involved in that process, but we have not looked at getting into expense incurred policies in that market. It would be difficult to take an expense incurred policy on an individual basis and compete against an HMO and PPO with some of the numbers they're doing today. You need that utilization control that comes out of the HMO and PPO.

MR. NACIN: It might be possible, when you think about the HMOs and PPOs, not to view them as the competition but as joint ventures. You could be partners, with them providing the reimbursement coverage and you doing something on top of that.

MR. JAMES A. ROBINSON: At USAA, we consider selling annuities to senior citizens a real opportunity as well as an opportunity to solve a problem. It is always a notion that when somebody retires at age 65, they get a lump sum of perhaps a quarter of a million dollars. There is always the chance that they will outlive that sum of money. We've developed a product we call the tailored income plan. We take any sum of $50,000 or more and we customize a series of payments. This is a little more popular than the typical single premium immediate annuity because, usually at the end of ten years, they want all their money back and we give it to them. So, in effect, we pattern the interest payments out to them. Of course, we do offer a life annuity option that has not sold. But they get their money back at the end of ten years, and then they can renew or buy another tailored income plan. We've had this out only a year or so. I cannot say it is a total marketing success, but we've sold ten times as many of these as we've sold single premium immediate annuities.

MR. LUND: So you'd say you at least have a hint at product design for this market, if not necessarily having your distribution cost under control at this time? Your marketing margins have to be extremely small.

MR. ROBINSON: Our costs are small. At USAA we send a newsletter to our members, and we tell them that we have additional products. We've already got the market. We don't have a problem with expenses, we have a problem with acceptance of the idea by our members. Our advertising cost is very slight because it piggy-backs on other communications we already send to our customers.

MR. BRUCE E. OLSON: I was interested in what companies do to control a great number of policies from individual insureds. For instance, on the Hospital Indemnity policies, if somebody has accumulated 10 or 15, obviously they intend to take advantage of you.

MR. SCEALS: You mean within your own company?

MR. OLSON: Right. Say you were to do an inquiry on your in-force file, and you found insureds who had a large number of a particular policy whether it was the Graded Death Benefit or the Hospital Indemnity.

MR. SCEALS: The approach that most companies take is to do the merge and purge before doing any mailing to eliminate them before you offer it again.

MR. OLSON: So you would not solicit somebody who already had one?

MR. SCEALS: It's obvious, if you have an underwriting rule that says you may have only one of these policies, that you would not want to offer it. It would be just wasting your money to offer it and then on the back-end reject it because of that. The best thing is to take them out of the list to begin with.

MR. OLSON: Maybe another way to rephrase the question is many times additional coverage is obtained by allowing upgrades or maybe a doubling in coverage, so it's probably not uncommon to have, say, several policies if you had allowed upgrades. Sooner or later you have to prevent this sort of thing.

MR. SCEALS: It depends on what the underwriting rules are, for example, whether it's of the same or a similar form. There is a lot that you can do to control your business, because a good thing about direct response is it is controlable business. The sophistication of your file will dictate what you can do. It's building the system to handle it.

MR. NACIN: A lot of companies have clauses in their policies that say they will not pay benefits on more than one policy. Either today or in the future, you ought to be able to have the technology to determine either how many policies or how many benefits are in force and control that when you make your offers. I ran across one situation where a policyowner had 15 Hospital Indemnity policies, and in the last offer, they had applied for 5 different Hospital Indemnity policies, and all the names were different. One time it might be initials, one time a full name, middle initial with a different address, at home, at the post office, at Mom's house, and at the office, so it's hard to control.

MR. OLSON: My company has a good bit of nursing policy business in force, and it probably has a great deal of appeal for senior citizens, but it's probably expensive on a direct response basis. Could a policy be designed that provided Hospital Indemnity benefits up to a certain age, with an accumulation period where money would be building in a fund for future nursing home benefits which can be very expensive?

MR. POLILLI: I've heard some of the ideas. It's an interesting approach. Some of the prefunding you may need for the nursing home coverage, and I've seen some agent-sold nursing home plans that have premiums of $700 to $1,000,is quite formidable for direct response. So

ways of cutting down on those going-in prices are needed to make nursing home work in direct response market.

MR. NACIN: You might be able to do something in the way of a convalescent policy, for example, where you tie the convalescent benefit to the basic benefit. In other words, if you spend 30 days in the hospital at $50/day, you've got $25/day for each of those days for convalescence.

MR. RICHARD L. VAUGHAN: Could someone explain or discuss the interrelationship between the use of DRGs, decreasing average length of stays, and the increasing average daily hospital cost in the 23 percent increase? In particular, what is the percentage impact of the 23 percent increase on the portion of a Medicare Supplement premium which is paying for Part A?

MR. POLILLI: We talked to HCFA. I'm not sure exactly how their formula works. It's quite surprising to come up with a 23 percent increase. But HCFA has a formula that is supposed to track the average cost per day in the hospital, as I understand it. I believe that with the DRGs shrinking the number of days of the average stay, your hospital costs are more expensive in your early days, so the average cost per day was going up because it was an average rather than recognizing that some of the stays have gotten shorter. So suddenly the formula pops up with a 23 percent increase which was unexpected. I know a lot of us in this room are scrambling because we're looking at the Part A cost as being maybe half of the premium if you're covering the Part A deductible. And an increase of 23 percent is an increase of 23 percent on that part of the premium.

MR. LUND: Another negative is the relative shift in benefits from Part A to Part B, which increases in some aspects our utilization of Part B benefits. Currently most of us are scrambling. We've had about two weeks to work on this and have about two more weeks in order to deliver our products by January 1 or in a timely fashion for January 1. With Medicare, keep in mind that your actuarial staff is working with a small quarter to react annually to changes in the benefit.