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TRENDS IN NONTRADITIONALLY MARKETED HEALTH PRODUCTS

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- o Products
- o Distribution methods
- o Experience

MR. R. LARRY PETERSON: We will discuss several aspects of nontraditionally marketed health products, including various types of coverages, marketing trends and strategies, and experience and trends by product. I expect this will be especially informative since the three panelists joining me represent the consulting, the marketing and the insurance company viewpoints.

Richard Pitts is Assistant Vice President and Associate Actuary of Continental American Life Insurance Company and has extensive experience with these types of products. He was formerly with American Health & Life Insurance Company.

Frank Polizzi is President of Mass Marketing Insurance Group, a firm which specializes in marketing, consulting and brokerage activities for the direct response insurance and financial services industries. Prior to starting this company, Frank was Senior Vice President at Colonial Penn Insurance Companies and before that he was with Allstate Insurance Company where he was Director and Profit Center Manager of Allstate's direct response operations. Frank has

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spent over seventeen years in the direct response insurance field and is with us today to address marketplace issues that affect nontraditionally marketed health products.

Bradley Smith is a life and health consultant with Milliman & Robertson in their Dallas office. He was formerly Vice President and Chief Actuary at JC Penney Life Insurance Company where he was responsible for direct response marketing analysis, product development and list segmentation.

MR. RICHARD D. PITTS: I'd like to talk about some of the products and product changes we're seeing in the direct response marketplace. I've been involved in the development and marketing of direct response insurance products for several years. At Continental American, we're pursuing sales endorsed by financial institutions and other affinity groups, to broad segments of the population through television, direct mail and telephone supported campaigns.

There are several products that have been the standard bearers for the industry. For the markets Continental serves, these include accident, hospital indemnity and medicare supplement plans. For the association market, served by others in the audience, we should add hospital expense and disability income products.

The body of experience that has developed and the careful drafting of policy forms has allowed us to provide nearly all of these standard products on a guaranteed issue basis. However, that same familiarity has caused saturation in many of the market niches that have been carved by direct marketers. As a result, we've seen response rates drop, the strength or value of endorsements weaken and acquisition costs continue to rise. Hospital income from credit cards is a prime example. Here, response rates are less than half of what they were a few years ago, and production and mailing expenses have doubled.

Accident products have been particularly hard hit. The product was and can be an excellent lead product. It offers a large accident benefit at a low premium and can introduce a customer to the services offered by the company. Claims incidence is infrequent and the risk can easily be reinsured to reduce fluctuation in the financial statement. For a direct response campaign, a large group is needed in order to achieve economies of scale and maintain a reasonable

acquisition expense per name. List analysis and segmentation are keys to success. For example, 10,000 ineligible names or addresses could cost $2500 to $4000, and require up to 100 paid policies just to pay for these errant names. Yet, a successful campaign can cover its costs and provide excellent opportunities for telemarket and policyowner market sales.

Hospital income products have been a favorite, particularly in the financial field. Response rates have decreased over the past few years however, as many competitors' products and kits have begun to look alike, as lists have been worked and reworked, and as credit card bases have been traded back and forth by our clients.

Indemnity benefits have risen to the point where we're offering $40-$80 a day and higher depending on the nature or specialty of the target list. Most plans reduce benefits at age 65 for the early portion of the benefit period to provide for coordination with Medicare and to reduce the required premium outlay. Elimination periods are usually 0-3 days so immediate cash benefits can be promoted. Benefit periods are generally in the 2-5-year range. We've gotten better at ferreting out fraudulent claims (or maybe the claimants have gotten smarter and we haven't found out yet), and right now the prime concern with morbidity experience is the impact that AIDS and ARC claims may have.

Medicare supplement plans have, until this year, been quietly rolling along; except in October when we pricing actuaries frantically seek and price for the benefit increases, and from November thru January when Eddie Albert and others take to the airways for our media campaigns. Due to legislation, benefits coordinate well with medicare, and packages are now very similar. Persistency is becoming a concern as we find ourselves trading policyholders. However, most recently, the proceedings of the Bowen Committee, the introduction of several congressional bills on the national front and the activities of state legislatures and insurance departments have promised to heat things up considerably and keep several of us busy in the pricing and product development area. Definitely stay tuned to this station!

I haven't been recently involved in the hospital expense and disability income markets which seem to be limited to strong affinity groups and associations. The medical expense products now marketed have high deductibles geared to

supplement employer plans or cover self-employed professionals. During the discussion, I would like to solicit comments from those of you with experience and knowledge of trends in either area.

Entrants in the "not new but still discovered" area include the return of premium products. Originally developed as a disability income product feature, the return of all or a large portion of the premium upon a specified event such as the 5th or 10th anniversary has crept into hospital income and accidental death products. At Continental we developed a 5-year return of premium Hospital Income Plan (HIP). The premium return benefit is difficult to price in a cash flow product like HIP due to the spiral effect between premiums and the return benefit. Product developers must carefully investigate and comply with several state regulations that govern the return of premium feature. But even with these difficulties, a product like this can attract customers and improve persistency.

This year's new products seem to be centering around the need for long-term health care. Every week our industry papers carry articles on new entrants, products or regulations in the field. At Continental we've developed and just introduced a nursing home indemnity product. The product is similar in concept to hospital indemnity but provides coverage for qualifying stays in convalescent and custodial facilities and also provides a home recovery benefit. Like hospital indemnity and other direct response products, the concept is to stay simple and satisfy a recognized need.

Pricing is particularly interesting. Company experience is closely guarded and difficult to come by and the 1977 Nursing Home Study sponsored by Health and Human Services has limitations which require the careful scrutiny of the pricing actuary. Pending legislation on long-term care must be continually reviewed in order to prepare a reasonable policy form and benefits. I'm pleased to say that several jurisdictions have recognized the experimental nature of the products and have been very helpful in the development of the first generation of products. Our policy, like those developed and tested by other direct response writers, is underwritten. We've taken special care to develop administrative procedures that will speed the underwriting process without losing valuable information that could lead to a wrong decision. This is a double-edged sword that needs to be handled carefully.

Long-term health care underwriting is different than most other underwriting to which we are accustomed. Applicants are not the young, generally healthy people who submit clean, short form applications for direct response term insurance. They are in their 50s, 60s and 70s and have a substantial history of ailments and hospital confinements. (Watch out if they don't!) Too cautious an underwriting stance will result in the response rates dropping to levels that will not sustain the marketing effort. Too liberal an underwriting process will lead to a trail of long-term claims, undesirable rate increases and a hasty exit from the market. There is a need and opportunity to create a balanced application that is short enough not to scare off direct responders, yet still elicit sufficient information; to establish a follow-up process that obtains the information needed to disqualify the worst risks with the speed necessary so you can place the business; and to obtain sufficient financial information without reaching the point of perceived invasion of privacy. And again, every effort must be made to keep the process swift and simple in the view of the consumer. Here is a prime example of where our actuarial expertise can be used not only to price but to build bridges to the marketing and administrative areas to produce an effective and successful product and program. It will be interesting to follow the future development of products and players in the long-term health care field.

MR. FRANK S. POLIZZI: I'd like to talk about our nontraditionally marketed health products and trends in two areas: marketing and the product. My perspective is based on a little bit of common sense. In terms of marketing, if you've worked at all in the direct marketing field, it's time for all of us to say that some of the old tried and true direct mailings, mass mailings, involvement devices, and $.25 first month offers just aren't enough to carry it anymore. The trend is such that, unless you're very innovative and you've really analyzed the marketplace, you're just not going to make it with vanilla marketing anymore. So, in a nutshell, that's the marketing trend.

In terms of the product trend, I think Mr. Pitts just introduced it to us and I sure agree with it. A lot of the products that we think of as the traditionally marketed supplemental direct response products, HIP plans and the accident/hospital indemnity plans, scheduled accident, and accidental death and dismemberment (AD&D) are probably not going to make it anymore by themselves. My perspective is to think back and reflect on how we got into some of these products. The way they developed as supplemental products means that they filled a

gap. For example, take the hospital indemnity product. When the market place was moving toward longer hospital stays and hospital confinements, hospital cash plans made sense, but today hospital stays are down. The trend is entirely to get people out of the hospital or not to get them in at all. Outpatient surgical, recuperation type facilities, etc., are the gaps today that, as an industry, we need to be spending more time reevaluating. Where are the gaps? How do we fill those gaps?

This leads into my next issue, understanding the market. I think we also have to be smart enough to remember that our internal analysis as an industry of what the gaps are have to be matched with what the consumers think the gaps are. I recently have been involved in some consumer research exactly for this reason. I think you have your eyes opened very quickly after a lengthy analysis of all the types of things we're trying to do in a health care delivery system. Consumers don't quite see all of those things. We can't introduce them in the form of a product until the consumer is ready to accept them. As one little example, we, of course, know that the medicare supplements feel Diagnostic Related Groups (DRGs) are the way to go now and the consumers know and understand the DRGs very well. So, we felt that since many providers are now trying to reestablish claims payments systems based on prospective payment plans, we might introduce that to a younger market and have them understand that the hospital's incentive is to get them out earlier. The overriding conclusion of the people is that this isn't the way it works and that there is no such thing as prospective payment systems. So, that is an example of how the product could be right to fill those types of gaps where a person is getting out of the hospital earlier. If it's not done the consumer is not going to accept it.

I would like to cover two things, and obviously we are only going to touch on the tips of the iceberg. First, the evaluation of the marketplace, a little further in depth than what I just talked about. Second, the role of the actuarial discipline in the direct response marketplace. Fortunately, I have had a career that allowed me to spend time on both sides of that coin and I feel that it has been very enlightening to me and helps me try to relate to some of the things that we think about every day.

First, let's talk about understanding the market. When I wrote down the characteristics, I was trying to come up with a couple of words that seem to make

some sense. All we are trying to do here is understand the marketplace. We need to look at who it is that we are marketing to exactly. Even the marketing people often make the mistake of not defining the market, not setting up objectives, not understanding who the people are or where they're coming from, and what they have seen in the past. We really need to evaluate that and we will in more detail. The important thing is that you understand that market and that you understand a direct response market, whether it is health products or anything else. It really is a market oriented business. You have to start with the market and develop a product that meets that market or you probably are not going to succeed. It will drive both the product and the offer (the way that product is presented to the consumer). It is different from those of you who deal primarily in the agent distribution system. There, your market is the agent and you are trying to come up with a product that the agent will embrace and sell to the consumer. Here, you are communicating directly to the consumer. It is very interesting and very satisfying.

Leading from this, I would like to talk about a marriage of actuarial and marketing disciplines, which I think works. After many years in the business, I don't really see it happen very often. When I bring it up, I am always curious because people tell me that they do that in their company. "We get along just great with our marketing people and with our advertising people." I don't see it. I know what the marketing people don't know from talking to them, and I know how much the actuarial profession does know and how much is not really being tapped. I think you have a responsibility to set up the rules and boundaries with your marketing people to get to know what they are thinking, rather than just go in and say, "Do this." Rather than just tell them your acquisition costs are $105 per policy, give them guidelines. I think you need to get inside their minds a little bit to see what they are trying to do. They have ideas. They know what they want to advertise. They know what they want to market and the media they want to use, but they really don't understand the implications of the acquisition costs. They don't understand the implications of persistency and conservation. As a matter of fact, there are very few companies that have ever been able to show me someone who is either a vice president or a director in charge of persistency. In a direct response business, far more profitability can be gained by managing the persistency better than by the upfront response rate. Also, no one has ever come to me and said, "Well, our acquisition costs guideline for a conservation program is x (maybe $40 a

policy)." And yet, to replace lost policies, it costs just as much as to bring them in the first time. You go back with strong conservation efforts and if you trained your marketing people properly, I think that you will find it has a big impact on profitability. Giving them the rules really helps them use their ingenuity.

The point that I am trying to make reminds me of the NCAA final this year. This year in college basketball, they introduced the three-point play. If you remember back a year ago, right after the sneak vote went out to get that rule passed, most coaches condemned it. But they sure used it, once they knew what the rules were and they sat back and decided how to do it. The seven 3-point field goals made the difference between winning and losing for Indiana. The same is true if you would work closer with the marketing people. Give them the rules, help them look at it different ways, and I think you'll find that you will have more successful campaigns.

One thing that is missing in a direct response system is a sales manager. I think the actuarial division can become that sales manager, work closer with the marketing group, set up the type of report card that will be evaluated, and help them do this. I have heard things from companies that can't be believed in terms of how they (marketing) can interchange upfront list fees with commissions. It is absurd how much they think they know. It's obvious that there is not much of a link between them and the actuarial people. Listen to them talk about acquisition cost guidelines. They invariably will ask, "Where can we spend the $150 that has come in from a life policy?" instead of trying to reposition those dollars, and say, "Maybe we can use some of those, for example, in a return of premium policy. Or maybe we can reposition those to come up with a special promotion." I have seen some pretty poor attempts at giving away "free insurance," but when you sit down with the marketing people, if you have them understand that the acquisition costs don't just mean "print bigger envelopes," they will come up with better results for you.

Let's address this marketplace. I don't like to think of this as back to basics, but what I'd like you to think about as I go through the marketing issues, is to have you scratch your brain and decide how you can attach some actuarial guidelines or scoring methods to the things we are going to talk about here, because they really can be done. The first one is the characteristics of the

marketplace. When you are looking at the actuarial program, what do you really think you ought to be talking about with the marketing people? Where is your company headed? Is your target to make use of some affinities or sponsorship or endorsement or is it out there in the general marketplace? The more you understand that, the more you'll realize that there is a real value attached to this, without question, both in front-end response rate and in back-end persistency.

One of the problems with the general marketplace is that you don't end up being substantially different. (Everyone seems to have basically the same products today in the medicare supplement field and the only difference is which celebrity endorser is going to be used and which golf course they are going to be on when they talk about their medicare supplement plan.) If you do come up with a winner, there's no stopping any competitors from coming in and copying exactly what you've got. And you've spent the developmental dollars and you've begun to lose the market share. That is the first thing we have to look at.

What kind of an automatic billing system are you using? By automatic, we mean credit cards, a preauthorized check, electronic funds transfers, or any kind of automatic debit approach. If you don't have your finger exactly on what the persistency differences are, you should. First year lapse rates are probably double through direct billing compared to the persistency that can be achieved in a credit card billing situation, for example. You can evaluate that on the basis of some kind of scoring method as well.

Another thing I would like you to think about is whether your market/mailing campaign has the ability to evaluate specific data about that marketplace or whether it is inferred data. In a controlled file environment (oil company, retail file, even an association group), there is specific data that you have about those consumers. If you build a profit model, you can go back in and select people for the next campaign on exactly the same information. By inferred data, I am referring to census information and cluster analysis which attempt to achieve the same type of profit modeling capabilities but don't quite get there. There is a real value on that and something I think that can be translated into numbers. Do you have the ability to launch campaigns with the marketplace that has events that you know about? (Is there a new member or a new policyholder or someone who just bought a rider or just made a retail purchase?) These events

link that marketplace hopefully to that affinity, and hopefully to test other market characteristics. Compare that to a situation where there is really no transaction data, where you have to go out and rent the list, and the best you can do is maybe have a monthly or quarterly hotline. Again, you are into the general marketplace and there are major differences. On a very simple comparison, we might be talking about a 50% increase in sales just because you link something to an event about that marketplace.

The last thing which relates to segmentation is an evaluation of the size of your market. This will vary a lot and you will make your own determination about a good size. You might decide that based on segmentation modeling and the technique you like to use, based on the efficiencies of your purchasing, ability to print and deliver mailings and letter shop activities, etc., that you will develop your own economy of scale. One of the problems with a small universe is that there is a red flag that should go up because you tend to build yourself into a box, or paint yourself into a corner. If you end up in a direct marketing campaign where, when you're done, the only conclusion you've come to is that it worked or it failed, you've allowed the wrong type of campaign to be launched. You always want the ability to have a large enough universe so that when you begin to test that universe you know your goal is to carve out the portions that work. When it begins to get too small, very often you find yourself in a situation where if it doesn't work, there is no place to go. It is not a good situation to be in.

Let's move to the event driven concept. What you really ought to do is establish something that I always like to call transaction based marketing, because I really believe the days of our mass mailings or rollout campaigns could be over. Over the last 15 to 20 years, we did many mailings. Back at Sears, we'd mail 15-20 million pieces at a time because response rates were so good and postage was so low. Today, response rates are down. We have to work harder at segmentation, costs are way up and you have to be smarter than ever before. The way to do it now is to link the transactions. Actually, it has some overriding benefits and the operating people have always tried to get us to do it. They have always had a problem with big peaks and valleys (justifiably so). The marketing folks like to say that January and February are big marketing times and you never want to make a mailing in July. You certainly don't want to make it in late November or early December. You end up with lots of peaks

and valleys and lots of problems for the operating clerks. One of the things that has been successful for years is that when you set up these transaction based marketing plans, you can drive them down in your organization so that they are run continually month after month. Why can't we just set up a campaign so that 30 days after the new policyholders join the company, they get a certain type of offer based on what they bought, their family size, the amount of premium, etc? When they are a new member or credit holder, why can't we just set up a campaign that goes forever beginning 30 days after they get their credit cards? Those are your most profitable campaigns.

I've tried to come up with a list of events that will link the marketplace for you, because I think this is where we might want to look. Contact policyholders, who have made a new purchase, a big purchase, a claim (in certain situations this could be an opportunity), a policy change, a premium reduction, or even a customer service transaction that you handled well. Then there is the opportunity of inserts in billing notices. Contact them on their birthdate or their anniversary date. This is far more profitable than any of the big campaigns that we could ever launch and it's where we ought to be anyway.

What it really leads me to is an analogy that I used for the first time six months ago. In the direct marketing field, we ought to begin to learn from the agents. The agents don't go door to door just because someone has a bell to ring and say, "Well, since you live here and have a doorbell, would you like to buy a term life policy"? The resident would say, "I don't know what you're doing here, but I do not want to buy a term life policy." This is what we find ourselves doing. Because people have a mailbox, we send them a mailing. We put commercials on TV. We really need to begin to get back to what the consumer has seen from the agents. There is a need and they identify the need. They don't just go door to door. Agents come up with things that we have begun to use. Some companies are successful with birthday campaigns. Some companies are successful with mortgage or homeowner's insurance by going to the courthouse files and pulling out records of people who are buying. They cut deals with real estate agents. They use what they know works. What works is the right idea at the right time and for the right reasons. That is what I think our industry needs to do: to get out of the trends that we are in right now, which are kind of down. We don't have the right kind of products that work in the marketplace today. We don't have the right kind of marketing skills; response

rates are down, costs are up. We need to get a little smarter. When you think of your campaigns and all your skills, work with the marketing people to be right. This means the right reasons, and the right ideas, at the right time. I think that will curve the trend.

MR. BRADLEY M. SMITH: I am going to expand on what Mr. Polizzi and Mr. Pitts said. Specifically, I am going to talk about a few product trends that I've seen in the industry. Additionally, I am going to expand upon what Mr. Polizzi said about the difference between marketing and sales and what that really means. Finally, I am then going to summarize something that is of concern to all of us in the product development area in the insurance industry -- the regulatory issues surrounding AIDS.

As Mr. Pitts mentioned earlier, one of the product concepts that seems to be resurfacing in direct response is the return of premium concept. We've seen this for over ten years now (close to fifteen). The original products were return of premium based on no claims for so many years. The original product required no claims or few claims in the first ten years, for instance. These types of products are resurfacing and we're seeing return of premium based on no claims for five years or ten years from the last claim. These get you into administrative problems since you have to capture the claims on the master file in order to determine the reserve, and also determine whether the person is entitled to receive the return of premium benefit.

The version of the return of premium concept that I find interesting is the return of premium based on persistency. As Mr. Polizzi and Mr. Pitts both stated, the key elements to the success of a direct response marketing effort, if defining success as the overall profitability of the effort, are overwhelmingly the response and persistency. Morbidity, accident experience, or mortality experience are certainly critical, but would be minor by comparison to response and persistency. If nobody responds, you will lose a lot of money. If a lot of people respond and they all lapse in the first few years, you will lose a lot of money. The return of premium based on persistency is an effort to try to succeed at the first two critical elements of success in the marketing effort, persistency and response. These products, whether it is the standard AD&D product with a common carrier, or a hospital product, will return the premium to the consumer after so many years.

Exhibit 1 is an example of an accident hospitalization product. We've run one easy profit study to show you the effect of providing this return of premium benefit. This particular study shows a 45-year old male. Eight percent interest is assumed in all years. (I must mention that when these products first hit the market about two or three years ago, interest rates were much higher and the effect on the premium of the return of premium benefit in the pricing process was substantially smaller.) This annual premium is $34.95. The way we got this was to use the pricing without the return of premium benefit and assume a 40% loss ratio. A $100 per day accident/hospital benefit is provided. The morbidity expenses are based on guaranteed acceptance. We tried to set termination rates typical for direct response offerings. Termination rates are 30% in the first year, 24%, 18%, 14%, 10%, 8% and then 6% beginning in the 7th year.

This final assumption that was used is a critical assumption (percent of terminations by month in first policy year), and I've seen it used improperly in two ways. One is not to use the assumption at all. Basically, in the first 12 policy months, if you had 100 people, and 30 terminated, 12% of those 30 are going to terminate after the first month; that is, not pay the second month premium. What you have is 33% of your first year terminations happening in the first 3 months. It is extremely critical to use this assumption in a direct response product development because the key is getting premium income to recoup your marketing expenses. It's not as critical in a commission driven system where commissions are paid as premiums are paid. So, one mistake that I've seen is not incorporating this type of an assumption. You can swing your profit margin 3 to 4 points easily, if you assume a uniform distribution of decrements.

The second misuse of this assumption that I've seen is where companies are looking at a mixed mode lapse study, where annual modes and monthly modes are all mixed in. In fact, if you look at your monthly premium payment mode business only, what you're going to find is that there is no reason why the 13th month lapse rate would be any higher than the 12th month lapse rate. There is no major difference.

Table 1 compares the results that we found. Termination 1 is the termination rate shown in Exhibit 1. We also assumed no terminations. As you can see, with no return of premium, it was priced for a 40% loss ratio. Present value of profit and the defrayal of all expenses, including marketing expenses after 20

ASSUMPTIONS

ISSUE AGE: 45

SEX: MALE

INTEREST: 8% ALL YEARS

ANNUAL PREMIUM: $34.95

BENEFIT: $100/DAY ACCIDENT HOSPITAL (GUARANTEED ACCEPTANCE)

TERMINATION RATE:

YEAR	1	2	3	4	5	6	7+
	30%	24%	18%	14%	10%	8%	6%

SKEWED TERMINATIONS IN POLICY YEAR ONE AS FOLLOWS:

	POLICY MONTH											
% OF	1	2	3	4	5	6	7	8	9	10	11	12
TERMINATIONS	12%	11%	10%	9%	9%	8%	7%	7%	7%	6.67%	6.67%	6.67%

TABLE 1

COMPARISON OF LOSS RATIOS AND PROFITABILITY

	TERMINATION 1		NO TERMINATION	
	LOSS RATIO	$PV(PROF)_{20}$*	LOSS RATIO	$PV(PROF)_{20}$*
NO RETURN OF PREMIUM	40.0%	79.17	37.3%	224.41
10 YEAR RETURN OF PREMIUM	69.7%	39.95	79.2%	74.43
15 YEAR RETURN OF PREMIUM	61.3%	51.00	79.2%	74.43
20 YEAR RETURN OF PREMIUM	55.4%	58.88	79.2%	74.43

* INCLUDES PRESENT VALUE OF PROFITS AND CONTRIBUTION TO THE DEFRAYAL OF EXPENSES

years discounted at the investment earnings rate was $79. You can see how your loss ratio really skyrockets. The 10-year return of premium benefit, even at a relatively high lapse rate, is very expensive. That is why you are seeing 12, 15 and even a 20-year return of premium benefit. Obviously, your loss ratio goes down significantly and it's a tradeoff. It's not so much between your loss ratio and the benefit you offer, but between what kind of premium you have to charge and how responsive you feel your audience or your market will be to that.

The other example, obviously this is an extreme, is no termination. The only point that I want to make here is, obviously with no termination, the assumption was that you've funded the return of premium benefit after the 20 years, so that the loss ratio for each of the benefits was the same; 10, 15 and 20, compared to 37% or near 40% for no return of premium. The key that I want you to get from this is that when you price this return of premium benefit, what you're doing is insulating yourself from major swings in changes in persistency. If you priced based on expected persistency, and persistency falls off, your return of premium benefit will be falling off. If your persistency improves, you aren't going to participate as much as you would if you didn't have the return of premium benefits. What you are doing is taking one of those critical success factors and shifting some of the risk to the responder to this policy.

Exhibit 2 shows more results based on absolute dollar amounts. Under termination 1, which is the standard termination assumption, the present value of premiums is $132. With no termination, the present value of premiums is $350. Your premium income has gone up substantially, also. You're insulating yourself from persistency swings.

Another reason this product was developed, obviously, was due to hospital utilization being down in the market. Mr. Polizzi will tell you that the market perceives this. They do not feel as great a need for a hospital benefit product. They don't see themselves utilizing the benefit. Additionally, the state insurance departments know this and companies run into loss ratio problems. One of the things this does is increase your loss ratio. Using different termination assumptions, you can get any loss ratio that you want. It also affects the primary success factor and that is the responsiveness of the market. These products are definitely more responsive than the nonreturn of premium benefit.

EXHIBIT 2

TERMINATION 1

$PV(\text{MORB EXP})_{20}$	=	52.77	$PV(\text{SURR EXP10})_{20}$	=	19.63
$PV(\text{RESV INCR})_{20}$	=	19.59	$PV(\text{SURR EXP15})_{20}$	=	8.58
$PV(\text{PREMIUM})_{20}$	=	131.94			

NO TERMINATIONS

$PV(\text{MORB EXP})_{20}$	=	133.36
$PV(\text{RESV INCR})_{20}$	=	149.97
$PV(\text{PREMIUM})_{20}$	=	357.77

You've heard of "I don't need this benefit and I don't see myself using this benefit." You've addressed that issue by saying, "OK, take it for 15 years and if you don't use it, you get your money back." It helps to improve the responsiveness of the product.

This product concept does have some interesting ramifications as far as how you run your marketing effort. Obviously, one of the things that contributes greatly to the profitability of an overall marketing effort is the policy solicitation program or the back-end marketing. You're creating a list and you may or may not be making money on that front-end solicitation. You're hoping for and anticipating profits from solicitations to these policyholders. Administratively, the companies that I know of, have found it very difficult to administer the riders any different than the policy. So, if you add riders onto this policy, which can represent anywhere from 30% to 70% of your back-end marketing effort, they will go on your master file and you will return those rider premiums 15 years from the issue of the original policy. Well, that is critical. If you say that an active policyholder file can be maintained for 7 years without a response (that is you keep making solicitations to the policyholder for 6 or 7 years), profitably you are segmentating from the time of issue of the original policy. After 7 years, you would not solicit him anymore because his responsiveness is such that the profitability is down. That period (6 or 7 years) is reduced dramatically because you are going to return the premiums on the riders to that policyholder. What was profitable 7 years from the original issue of the policy is no longer profitable from a rider standpoint because in 8 years you have to return that premium to him (i.e., 15-year return of premium). You should really consider that your back-end marketing potential reduces as you reduce the period of time after the issue of the original policy from 6 or 7 years to 3 or 4 years. That's critical in your overall profitability.

Another product concept that I've seen, and I'll only touch on because I have not seen it on the market yet, is the tuition/accident product. Obviously, we've all seen tuition/accident products where the parent dies and all the kids get $5,000 per year for 4 years upon attainment of age 18. The concept that I have recently seen is tuition/accident with no specific face amount. It's tuition/accident reimbursing the tuition of the child whose parents died from accidental death, based on the school that he attends. Obviously, that creates tremendous pricing problems. State regulatory problems have kept this product

from going to the market. At this point, the difference between going to a state school or a junior college and going to an elite private school can swing the benefit $14,000 a year for four years. Obviously, we're very comfortable with pricing child type rider benefits where the company is taking the additional risk of how many children the policyholder has. This new concept is on a per child basis, so that you've eliminated that risk, and accepted the additional face amount risk. Additionally (generally priced on a guaranteed renewable basis but unlike medical reimbursement), the accidental death risk is not what you're worried about. It's the payment uncertainty and waiting 10 or 12 years before you find out what college this child will attend. You can't really raise the premium because your accidental death experience can be exactly as expected; it's just that your death benefit is different. I don't know if that will get by the states or not. Certainly, if it does, it opens up a whole array of product possibilities, limited only by the marketing manager's ingenuity, i.e., divorce policies and other things where you're just accepting greater and greater risk.

Another product concept that I want to talk about that Mr. Pitts touched on is in the long-term care/nursing home market. By the year 2000, 13% of the population is expected to be age 65 or older. There are now 2.2 million Americans over age 85, the beneficiaries of this type of benefit. This number is expected to double in the 1990s and reach 5.1 million by the year 2000. One out of every 5 persons over age 65 will need long-term care sometime during their lives. There is obviously a market out there. Continental American is coming out with a plan. We have seen press releases of Metropolitan coming out with a plan. Aetna has just come out with a plan that is being sold to employer based groups. Just to give you an idea of what the benefit is, they will provide coverage either in a nursing home or in a patient's home. There is a 90-day waiting period. It does not require prior hospitalization. It's an indemnity type benefit that pays $125 per day if in a nursing home, with a $200,000 lifetime max, $75 per day if it is provided in the patient's home with a $50,000 lifetime max and the premiums range from $20 per month for ages 50-54, to $65 per month for age 65, to $385 per month for ages 85-89. The critical thing that I have found in discussing this with the companies involved is that you have to get the premiums down to sell through direct response. We certainly had success in the medicare supplement market where a $40 per month premium is not unusual and $50 per month is not unusual for a Cadillac coverage.

The companies that I've worked with are trying to create the need at the younger ages, so that they can be funding this benefit. Therefore, they can make it a marketable plan. I've seen companies considering selling a universal life policy to 25 and 35-year olds so that it can be used as a funding vehicle for long-term care coverage. You aren't going to get a 35-year old interested in long-term care coverage. You are lucky if you get a 55-year old interested. What we are seeing is the difference in need and perceived need in the marketplace. There is no question that we probably all need this coverage. If we concentrate on need or theoretical need, we are going to be unsuccessful in our attempts in direct response. Agency efforts may be different. You have a person-to-person discussion illustrating the need. In direct response, we have maybe 2 minutes at most in a letter and possibly 2 minutes on the telephone to communicate that need to a person. That is an expensive proposition based on the response rates that we are going to get and it's a difficult sale. It's something that, until the public becomes more educated of the need (at a younger age) and the market is aware of the need, we are not going to see a lot of the success in direct response of this effort. It also seems to be a perfect example of the difference between product orientation and market orientation. Certainly, the market is there, but we are trying to force a product on a market that is not viewed as being needed.

I gave a talk at the Kansas City meeting last year about direct response regulation. At that time, there was something that had come out in an article condemning direct response insurers. Sure enough, last month a man named Max E. Lemberger, Senior Vice President of Allocated Capital and Insurance Marketing Corp. of Phoenix, Arizona, had a very good article, until the last column, on long-term care. He then really showed where he was coming from when he stated: "Unfortunately, the lack of participation by the professional agent opens the door to the unscrupulous marketing activities practiced by a small portion of agents and direct marketing companies. (*Best's Review*, February, 1987). He goes on to say in the article that professional agents are at a disadvantage compared to paid endorsements, because the people will listen to Eddie Albert or Michael Landon more than they will to the agent. He calls for more direct response regulation. Direct response advertising has got to be the most highly regulated part of the insurance industry. Writing new regulations isn't going to cure it. I think that we have to be aware that Mr. Lemberger is from a marketing group and is making statements from an agent/lobbyist viewpoint. We have

to be aware that there is that perceived need and we have to make sure that we are not adding to this mess. I think, certainly, an industry that offers medicare supplements through the American Association of Retired Persons (AARP), the standard bearer of the industry, can stand proudly and point to a product such as that. We just have to be sure that our claim practices are beyond reproach, so that we can eliminate this type of comment.

One other comment on the health insurance market in general is that I agree with Mr. Polizzi that the broad market is saturated, but there is a tremendous market out there and the key is to find an affinity with this group. Find an affinity so that you can market products profitably to this group. Now there are 35 million Americans who do not have any basic health insurance in either the private or public level. That's a tremendous market. We cannot go out to them through state drivers license lists or voter registration lists. You will have to find an affinity with that group in order to market profitably. Eleven million are children and 19 million are employed in low paying jobs, making it a tremendous market. In the typical direct response market, 4.6 million are unemployed adults, most living in families with income below $20,000, 30% live in families with income below the poverty level, 41% live in families with income below 125% of the poverty level, 12% live in families with income of $40,000 or more. We are talking about a tremendous market here. The question is how do we tap it, how do we gain an affinity with that group, so that we aren't sitting out there just replacing each other's policies, but actually creating new sales?

The last thing that I want to discuss is state requirements concerning AIDS. Washington D.C. totally restricts underwriting and does not allow blood tests, or a higher gross premium if AIDS or ARC is indicated. After 1991, insurers will be allowed to rate, but not decline, seropositive individuals if blood tests are determined to be reliable. States not allowing insurer blood tests are California, where you can't use ELISA or Western Blot; and Wisconsin, same as California, but that is currently under review and it appears that tests will be allowed. In Massachusetts, a policy statement prohibits antibody testing. States not allowing questions about prior AIDS tests are Connecticut, a rejection must include evidence in addition to blood tests; Maine, it's effective until October 1, 1987 that you can't allow questions about prior AIDS tests. In New Jersey, the insurer can require blood tests for health insurance only if the application

mentions symptoms or they are discovered during underwriting. Life and disability insurers can use the test. The insured must consent to being tested. States with limited restrictions on AIDS tests are Florida, which does not allow state sponsored blood tests as evidence; and Washington, blood tests must be ELISA or Western Blot to reject AIDS; T-Helper is not enough. We have proposed legislation which would prohibit blood tests in New York. There are a number of states that do not allow sexual orientation questions: California, Illinois, Washington D.C., Delaware and Wisconsin. There is a lot of concern out there in the marketplace about this.

I think that we, as direct response insurers, are in a better position than most because, as you will notice, none of these laws prohibit not marketing in areas where we don't want to market. They don't require that you broad market, so you can select, similar to a selection criteria for response or a selection criteria for persistency. You can select out areas that you do not want to mail to based on high propensity for AIDS claims, and there is no question that you want to do that. It is the same concept as selecting for high response, or selecting for high persistency. Obviously, people have been selecting for high response for a long time. Persistency selection is coming into its own in the major insurers at least. And if you are obviously successful, direct response companies have all selected for speculation, such as fraudulent claims, and professional insurance buyers. The concept is the same. We are obviously going to have to avoid areas where we do not want to solicit the policy. We are going to have to oppose frantically any legislation that prohibits this red-lining, similar to what the casualty industry regulations prohibit.

MR. PETERSON: Mr. Pitts, concerning long-term care coverage, you mentioned specifically the problems and opportunities that you could find in the 50 and over group. Have you attempted to market to the younger ages or create a need there?

MR. PITTS: No, we have not addressed this and we have cut off at age 50. The experience that I was able to gain and review for the under 50 market indicated that it is a very antiselective market, particularly for a direct response.

MR. PAUL N. FALCONE*: I just wanted to ask Mr. Pitts a question on the long-term care. Is the benefit period also 2 to 5 years or are you going beyond that?

MR. PITTS: The policy that we've developed has a structured benefit period. We have a 3-year benefit period for the convalescent care and a reduced benefit period for custodial care. The benefit period cuts back to one year and it cuts back to 180 days for the home recovery care. We did that primarily to come in with premiums that were marketable and because of this concern that we had with the nature of the long-term rates. Three years is the maximum. It is a lifetime maximum in our policy form. It does not restart in the event of a recovering second claim.

MR. SCOTT K. LUCHESI: I have been hearing for a year the same thing over and over again, which is that direct response marketing is ultimately relegated to providing supplemental products at low premiums. I don't believe that to be the case. I know our company is marketing first line high premium products on the life side direct response and has met with some success with it. I am wondering if any of you gentlemen would like to comment on why you feel that the direct response market has to be as it has been historically defined over the last 20 years.

MR. POLIZZI: Well, since it's a marketing question, I shall comment first. I think my comments today were directed primarily at the health industry. There, the direct response industry has clearly gone after the gaps in health care. We've got penetration by employer/employee plans, Blue Cross Plans, and some business sold by agents. There is nothing that has come close to that in terms of penetration in the marketplace with basic major medical health insurance coverage. I think that is why direct response is going after supplemental products. The other thing I would say is that simplicity of the product makes a big difference. I've been involved for many years off and on with automobile insurance direct response and homeowners' insurance direct response: the same products that agents sell. The ad can be done, but it is tough business. The bywords that you've always heard are true based on the facts. Unless you

* Mr. Falcone, not a member of the Society, is Account Vice-President of CIGNA Re Corporation in Wilmington, Delaware.

have a simple-to-understand product, which has simple-to-understand rates and hopefully low rates and high benefits, it is a tough sale. It can be done. The systems and technology are there, as well as the practice, but the economics are also proven facts at this point.

MR. PITTS: I think that GEICO has done an excellent job. I think one of the reasons that we've addressed it from a supplemental standpoint is primarily because that's our market niche. In direct response marketing, we tend to find and build our own market niche. Particularly for Continental, it has been supplemental type plans. For GEICO, it comes in at another level. With the higher premium plans, you are moving up against an agent in many cases, or a person who has been in direct contact with an agent or feels very comfortable with an agent. You may be looking at different administrative systems from what the company has developed to use for the supplemental types of plans. The sales process is different and it may be different for the marketing folks, because you're usually involved in a two-event sale. Keep it simple and yet provide the information that you need on a high premium type of product; I certainly didn't intend to exclude that. It is an area that the industry will be moving into more in the future. The first step is the ability to sell a higher premium in the medicare market where there is a direct involvement with the federal program and a constant orientation towards the need. We are going to be doing more of that with the long-term care products because they are a high dollar product. Also, we get into the larger life and annuity products.

MR. POLIZZI: It is a good question because it links back to something we talked about earlier, which is understanding the market. In the health business, I don't think it would be very fruitful to try and go out and sell a plan that is sold effectively through employer/employee relationships or now through HMOs, etc. Understanding the marketplace makes a difference. Also, one of the reasons that you might find GEICO being successful in it is this issue of affinity or sponsorship or linkage with the market. An example is USAA, which has probably been the most successful seller of automobile insurance in the country on a direct response basis. Why? Because they have the right market, the reputation, and everything holds together very well. When you have that affinity or sponsorship working for you, such as AARP, it opens up a lot of doors and that is what you will find overcoming a lot of problems in the industry. It creates a different situation for you.

MR. SMITH: I would say that there are certain truisms that hold for most people in direct response. I don't think that the high premium is one of them. I would say that the major impediment so far to tapping the market has been twofold. It requires tremendous market segmentation and accessibility to that market. That is going to cost the company money in developmental expenses and that is, generally, a way against competing with one's own agency force. As agency forces are falling off and traditional agency type companies are selling more through direct response, I think we are going to see that become less important than it has been in the last ten years.

MR. PETERSON: I would like to comment on a couple of these products that I have worked on in the past. It seems that I am working with two parameters. One, we need a certain level of premium to cover the cost. By that, I mean that you cannot have two or three dollars a month or it doesn't seem to be profitable. So, you do need a certain amount of premium and your response rate, of course. But, it also seems like some of the marketing people that I've talked with, probably with a lot more experience than I have, assume that your premium level has to be at such and such a level. We do try to keep our premiums within that range.

I would like to ask one more question to Mr. Polizzi. Do you have any specific recommendations or programs that you've used in the past to improve the persistency? This is such an important factor.

MR. POLIZZI: That is a broad topic and I wish I could devote this time to it. I don't think there are any simple answers, unfortunately. Number one has got to be the billing and collection system. We talked about that and you might say it's obvious, but the billing and collection system overrides anything else that you can do. Even if you find yourself in a situation where you don't have the credit card, or you're not marketing to a demand deposit account at a bank, and you have to go out and ask the person to pay by direct bill or provide you with information so you can bill them through Visa or Master Card, that's a place where you really want to begin to market. The answer to the question would be to emphasize bill marketing programs and try to establish some cost parameters within a direct bill environment to go after people to ask for credit cards. In a number of situations, I have encountered companies which feel that, if they accept Visa or Master Card, it will happen. It really doesn't. In a good

program, you'll be lucky to get 15% of the people in a broad market program to give you any kind of credit card or preauthorized check information. The advice would be to do whatever you can. Develop billing series, telephone outbound programs, and really market that. In addition, I think that you just have to get innovative reinstatement programs and get ready for lapses and make serious efforts toward conservation. There is no easy answer.

MR. PITTS: We learned from successful agents that the agency policies that have persisted are policies where the agents have been involved with the insured frequently, particularly with a direct response product or with a direct response company. Continual involvement with the insured is critical, not only with a particular product that you're selling, but also with the other services the company is offering.

MR. SMITH: The logical effect of that is that the policyholder or back-end solicitation should attempt to emphasize what the person has and whether what you're offering is adding a fulfillment of that need and reemphasizing the original sale.

MR. POLIZZI: Very definitely, the policyholder/marketing effort and telemarketing effort is different than the upfront response campaign, because you now know a lot about the person who you are dealing with. The more information that you can use is beneficial to both the company and the customer in providing services.