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HEALTH PRODUCT PROFITABILITY

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- A discussion of the profitability outlook, both long and short term, for various health coverage related products such as:
  - HMOs
  - Small group insurance
  - TPAs and ASO
  - Individual medical
  - Individual disability income

MR. DAVID B. TRINDLE: Our panel includes Ms. Barbara Niehus from Celtic Life, Mr. Jack Ladley from Huggins Financial Services, Mr. David Axene and Mr. David Baxter from Milliman & Robertson, and Mr. John Hartnedy from Golden Rule.

As most of you know, 1987 was one of the worst years ever for the health insurance industry and 1988 is shaping up to be almost as bad. In view of that, it is timely to have this subject reviewed as we plan for 1989.

MS. BARBARA NIEHUS: My topic is Small Group Health. I am going to address the market of 1-15 lives, the market that Celtic Life is in. Celtic Life is a specialty carrier and we focus on small groups. We've grown from entry in the market in mid-1981 to what will be about a $200 million block of business by the end of this year.

Small group, like group insurance in general, is a cyclical business although I'm not sure that the cycles coincide. The cycles for small groups seem to lag a little behind those of larger groups. 1987 and 1988 were definitely bad years of a cycle. Starting in 1984 and 1985 we had very good years and carriers became very aggressive. Trends were very low. Rate increases were low. The trends started changing in 1985, but we were slow to catch on, and slow to react. In addition, managed care was introduced to the small group market on a broad basis in 1986. Carriers were very optimistic about possible results and even offered big discounts for programs such as hospital certification.

What happened in 1986 was a double whammy. We underestimated trends and over-discounted for some of the managed care initiatives. The net result was that we were selling at rates that were not profitable.

Competition stayed very heavy through 1986, with heavy pressure on rates well into 1987. Carriers were slow to recognize what was happening because of the natural lags in developing experience. Small Group has very long lags, longer than Large Group, especially when a lot of new business is being sold. It takes small employers a while to figure out how to submit claims, so it took carriers some time to recognize those trends.

There is also the impact of the aging curve. Newly underwritten business always has favorable experience and it takes a while to realize if rates are inappropriate. The net effect was that the losses were not recognized until 1987 and continued to hit well into 1988. The market today is reacting. Short term, we expect to see the cycle turn pretty quickly in 1989 and 1990.

The long-term prognosis must consider the question: "Can the industry moderate the cycle?" Speaking from Celtic's perspective, the next time a cycle comes around, we will react faster. Early in the cycle, we saw the trend start to turn, but along with the rest of the industry, we underestimated the extent of cost increases. We will be positioned to be more cautious next time.

Small group has always been a very fractured market; it is not a market where a few carriers have big shares. As a result, it's a tough market to educate. There are always new carriers willing to come in and repeat old mistakes. That makes me a little pessimistic. Now we are seeing many carriers withdrawing. In the last eighteen months, we have seen over twenty of our competitors pull out of the market and we have not seen many new carriers enter. Some blocks of coverage are being outright cancelled and others are being assumed by other carriers. Originally, when carriers were first starting to pull out, they could get a small price for their block of business. That changed to where an exiting carrier might find someone willing to take it on an even basis. Some carriers are willing to pay a small price to another carrier willing to take an inforce block of business in order to exit the market. In this way, they protect themselves against potential lawsuits and against the ill will that is created when they cancel a block of business.

The other potential threat resulting from the turmoil in the market is Kennedy-type legislation. In 1987, Senator Kennedy proposed the Minimum Health Benefits for All Workers Act of 1987 (S. 1265). Currently, there is limited activity going on at the federal level, but there is a lot of state activity. The goal of these legislative initiatives is to provide coverage for all workers; make it both available and affordable. There are about 37 million uninsured Americans; 24 million of those are in families headed by workers. Many of those workers are low income, and many of them are employed by small businesses. This problem is going to be aggravated and highlighted as more carriers pull out of the market.

Insurance industry trends over the last few years have been to tighten up underwriting so that uninsurable persons are excluded and to apply preexisting condition limitations. Kennedy's bill would require community rating. It would require guarantee issue. It would prohibit preexisting conditions limitations, and it would regulate insurers by the Department of Health and Human Services. The impact of that legislation is obviously hardest on the small group carriers. The biggest negative to this approach is that it would increase costs for healthy groups who would have to support the less healthy groups. It would reduce small employers' options in choosing carriers and in choosing plan designs, and it would add another layer of compliance and reporting requirements. It would

basically and fundamentally change the market that we are dealing in at this time.

The challenge in the market, and what makes a carrier successful, is the ability to select good risks and manage the block of business properly. As soon as you take away the risk selection element the market changes entirely and becomes much more open to the most efficient administration, or perhaps government whim, depending on how the legislation is put together. Howard J. Bolnick, President of Celtic Life, has been actively working with the Health Insurance Association of America (HIAA) to propose an alternative to the legislation and to help educate the public. The HIAA has put together a proposal which consists of four parts: (1) to encourage employer participation with underwritten, low-cost insurance plans, and to suggest other alternatives that may help cut costs; (2) to provide coverage to employers with uninsurable groups through a publicly chartered private-sector-financed reinsurance corporation; (3) to expand Medicaid to cover all poor Americans; and (4) to cover the non-poor, non-working through broadly funded state plans.

Before I can be optimistic about our future in this business, there are two problems that we need to address and solve: (1) dealing effectively with the cycles and (2) participating in the solution to problems of the uninsured population.

MR. JOHN D. LADLEY: Third-party administrators (TPAs) have been a business in turmoil in the past twelve to eighteen months. Let's just describe, first of all, who the TPAs are and what they do, so we all have a clear understanding of the variety of terms thrown around in this business. I've put them into two major categories. First of all are the administrative only, who are probably the most numerous of the TPAs. They handle virtually any coverages, including pension as well as health insurance. The largest TPAs are in this category and many of these administrators have been the object of acquisition activity from carriers, group plans, and others who are looking to reduce the expense ratios they have in their own organizations. The second major category, and the one that I will focus on, includes those that do marketing and administration. These are less numerous. Their principal businesses are multiple employer trust (MET), small group, some medium size group, and association business. They sell a wide range of products, usually not including pension type coverages, and certainly including health insurance as the primary coverage. They are typically heavily reliant on their marketing function and the compensation for that to make good financial sense as an organization.

TPAs tend to be a cottage industry, even some of the very largest. That means they are all virtually family or individually controlled and originated. They are typically founded and run by former agents. Each one tends to be a valuable property in its own right. They are operated as small businesses. It is important that they are not at all run like an insurance carrier. When you deal with one, you have to look at the situation inside, the kinds of expense ratios, the kinds of supervisory ratios, systems costs and other costs that they generate. If you are thinking of competing with one, or being one, these expense levels must be reckoned with.

There are perhaps a thousand TPAs across the country, about two thirds of which are the administrative-services-only (ASO) type. The principal locations are in California, Illinois, Washington, Florida and a few other states. Their most common size will average the handling of about $20 to $40 million worth of

carrier revenue, which translates into between $5 and $10 million of administrative revenue. This can translate into about 10,000 or more customers.

The typical marketing and servicing TPA receives about 20-25% from his carrier, depending on what he is doing for that compensation. Beyond the 20-25% range, they receive 3-10% in additional billing fees, administrative fees, and marketing fees. There is also a variety of other creative methods for obtaining additional revenue. Of the 20-25%, roughly 9-12% goes to selling agents, general agents, and other people in the sales hierarchy. The balance goes largely to a claims function, if they happen to have a significant claims function, and to marketing, largely to the agents who sell the business. Most TPAs make a considerable profit and they typically have a worth of several million dollars. On the front end, as I mentioned in focusing on those that do the marketing, invariably, they also do the issue and underwriting process as well.

With respect to underwriting, there is a wide variety of programs and plans offered by the administrators. Often those are dictated to the carriers that they use. They are seldom dictated by the carriers. Not only do the explicit rules (those that you can pick up and read) vary greatly, but the implicit rules in terms of how they apply their underwriting and issue standards are quite important. Over the past two years there has been a very clear demonstration of the extreme value of solid underwriting by these TPAs. Virtually every TPA has different experience levels, so a given company dealing, perhaps, with a half-dozen administrators is going to see different levels and patterns of experience from those administrators.

The underwriting has a number of implications since there is a select and ultimate type of experience. There has been a lot of difficulty in dealing with that on the rating side and, as Barbara mentioned, with new carriers coming in and going out very quickly some of that select and ultimate underwriting has been misassessed. Underwriting has preserved, in a sense, the marketing edge that certain administrators have, enabling them to keep highly competitive rates.

Currently, there are numerous blocks of takeover businesses circulating in the market. They are being subjected to varying degrees of reunderwriting and to reimposition of the various clauses in the contracts and there is no one standard for picking up takeover business.

For whatever reason, most TPAs tend not to have a local market share. They tend to be national even if they're only in the $20 million size category. About 50% of the administrators actually pay claims. Virtually all at least prepare claims. The majority of their systems are home-grown, although there is a fairly wide use of just a handful of key vendor systems.

Data on claims from TPAs need to be well understood. A client must insist on getting quality claims data from an administrator. The varying practices in assigning incurral dates, making decisions on claims, claims audits, and all sorts of claims procedures have to be understood at the very beginning. Carriers with limited data (those that have obtained limited data from the TPAs, for whatever excuse or reason) have generally been those with the most serious problems.

A real positive in a TPA is one that is getting actuarial advice or even employing actuaries in their operations. One more thought on claims is that in a

pullout situation, for the carrier that is actually withdrawing from the business, claims wind up being the highly critical variable.

Many of the TPAs, going into this most recent market cycle, had only one major carrier. Therefore, with the withdrawal of many of the carriers, which Barbara alluded to, there have been several dozen orphaned TPAs and orphaned blocks of business circulating of late. Some of these blocks have been cancelled because of the relatively small size of the TPA, the lack of a critical mass, or the ability to get significant data. Some have just been cancelled because the carriers decided to get out of that business and, in some cases, the TPA has had genuinely bad business. The fact is that much of the business that is circulating out there right now is not necessarily bad business. Much of it is, but there are some good blocks of business that have been cancelled for reasons beyond the TPA's control. Certainly many TPAs have now learned that a situation they don't want to be in, in the future, is one where they are dependent on one carrier. They have also started to identify the characteristics of some carriers who are going to stay in the business: Those that, perhaps, are not using this revenue to meet Phase III -- Premium Income Limits; those that do not have extreme pressure on earnings, as in some public corporations, and are likely to withdraw as this business grows and cycles; and; in general, those that have evidenced a reasonably long-term commitment to the TPA business.

There is now a definite carrier's market and there is undercapacity, but when that capacity increases, as it surely will, then it may be difficult for some carriers to get back into this business, unless they find TPAs with short memories.

The most serious problem currently for TPAs is withdrawal from the business by their carrier. First, this may sever their relationships with their customers -- agents and clients. Of course, it severs their income, but most of them can move business if they haven't had their relationships severed. Second, from the claims side, which is the TPA's single biggest expense, they must continue paying claims and doing related administrative matters but perhaps with little or no income, depending on how quickly the cancellation occurred. There is, therefore, a severe disincentive to help the carrier, at least the old carrier, with the claims and that's why they are such a critical factor in a pullout. Remember too, the TPA generally has invested a great deal of training and image, and perhaps even dedicated personnel to a given carrier. So this is a serious problem.

Rate increases have been a problem and, in a sense, an opportunity for administrators. Predictions in the TPA business are that rates will be rising 30-60% in the coming year. This has been focused on by both carriers and TPAs in terms of compensation. The TPAs have looked at the agents to whom they are paying 9, 10, or 11%, and are making some hard decisions on reducing or restructuring some of that compensation. Carriers, in turn, are looking at both the agent element within the TPA compensation, as well as the compensation the TPA has received. There has been a much greater focus on matching of the service that is being provided with the compensation that is being paid.

Competition for TPAs is coming from carriers to a great extent. Some carriers are either buying or starting up their own TPAs. In my opinion, most will fail if they think they can compete with these fairly small, very nimble organizations that are run as small businesses. The self-insurance market is growing rapidly and reaching down into the TPAs business, so you will see many TPAs adapting to ASO type businesses as opposed to becoming or remaining as marketing-only

operations. HMOs are taking a larger market share, including the small group side, and this is actually the greatest threat to the administrators. In general, they believe that the HMOs do not have any fundamental rate advantage over them, but they do feel that there is a very substantial marketing advantage. Hence, they are pushing the renegotiations with agents and TPAs on the sales compensation. I believe the HMOs, as they become larger, will run into difficulty competing with these fairly flexible relatively low-cost TPA operations.

Another effect of all this recent change has been for many of the TPAs to move towards direct response methods for marketing. Section 125 was a marketing niche that many of them pursued to give them some better persistency experience in this business. It has started to work reasonably well in the medium size cases, but in the smaller cases, it has largely been a failure.

On the regulatory side, besides dealing with mandated benefits and COBRA and various other regulatory matters that are common throughout the industry, administrators are struggling with administrator statutes. These are passed by the individual states. They require registration of the administrator and payment of fees where many times no fees were payable in the past. These statutes often regulate whether an administrator can own or operate a captive type insurance company.

As Barbara mentioned, another concern of the TPA is mandated health insurance; TPAs are working very actively due to the fear of forced market consolidation. They recognize that one of their advantages, that is underwriting, is also a major disadvantage in this area because so many businesses cannot be covered in their current scheme of operations, and they must adapt to that. There is also considerable regulatory interest in the rerating process, takeover of blocks, and the tiered rating that certain administrators are using where a rate increase or other rate activity is spread or split among various segments of the business.

My conclusion is that if you are very careful you can make money with TPAs, but the underwriting and the claims functions of each have to be reviewed very carefully. You have to insist on an excellent flow of information and react quickly and decisively and even with some anticipation of market trends. Critical mass has become an issue in trying to deal with TPA, both for the carrier trying to deal with them as well as the administrators that they are looking at, to justify the level of expense. There will be some continuing reduction in market share. TPAs have actually enjoyed a very substantial increase in their market share over the past decade. Now it's actually shrinking, and there will be some continued reduction. They will be looking for, and I think probably obtaining, participation in whatever national health insurance program comes along. There will be some continued growth in premium and revenue and I think there will be a continued role for the TPA in the small and medium size group market.

MR. DAVID V. AXENE: I'm going to talk briefly about the managed care environment. We will be talking about anybody who's trying to manage health care. I am going to try to tell you what I see happening over the near term in terms of profitability but, more importantly, the overall outlook.

Barbara described the classical problems of the economic cycle and because the underlying health care system is cyclical in nature, the HMOs are subject to a very similar cycle. Fortunately, with their contracts, this cycle is dampened

compared to what you would normally see in an insurance company environment. One of the big advantages of contractual arrangements with providers is that you can dampen some of the cycle. The valleys are more shallow, the peaks are less high. The real interesting thing is that both in the commercial carrier environment and in the managed care environment, if you add up all the pluses and subtract all the minuses, you will find that without investment income the health care business is a net loser. The business itself tends to lose money and you use up too much of your investment income. If we take a look at the short-term, I think we will find, from our financial statement background, that we need to look at profit and loss from several different components. The first is the profit and loss from the health care management side. Are the health care costs within the budget, or whatever plan, from the very beginning? There are a lot of plans that aren't making those budgets. There are a lot of plans that are. Which plans are actually controlling health care? Which plans are actually managing health care? I'm convinced that as we manage health care better, profits go up; so if you want to increase profits, you've got to manage health care better.

Provider sophistication is hurting the industry right now. Providers have been hurt quite a bit and are waking up. They are starting to hurt us a little bit in the form of harder negotiations. The short-term outlook for this is decreased profits.

HMOs and carriers haven't been very smart in how they allocate risk and try to share risk. Many of our multiple option products are falling apart. Many of our newer product designs, because of poor reinsuring issues between the carrier and the HMO, are losing money for the carriers while the HMOs are making money. In the long run, joint ventures will probably decrease the amount of money to be made.

Probably the biggest problem with profitability is one of volume. HMOs don't have enough membership to cover their fixed costs. If they get the membership they are going to make the money, assuming of course, that they control care costs. If they don't get the membership, the fixed expense side will kill them. We see a lot of plans with expenses at 30-40% of their annual income. Obviously, you can't make money with these expense levels, but as soon as you get the volume things will turn around.

Adverse selection management, or trying to figure out what adverse selection is, I see as a most critical issue, both in the short term and the long term. The HMO plans that are understanding how to manage adverse selection are the ones that are going to be winning in the future. They're the ones that are going to be making money. The ones that ignore it and watch it deteriorate are going to have problems.

The new HMO regulations are opening it up for managed care plans, at least the federally qualified ones, to start doing a lot more sophisticated experience rating. The nonqualified plans have been experimenting with experience rating for quite a while. Some HMOs have been renting their system out on an ASO basis. When alternate financing schemes hit the insurance companies and they moved away from fully insured products to ASO and self-funded products, there were decreased profits. There's less risk to take by the carrier or the HMO; therefore, you don't really have the right to make as much money as you used to.

However, in the short term, there are only three things that I see that have any chance of increasing profits: managing our adverse selection, managing the health care, and getting more business. Fortunately, we're almost through the bad part of the cycle, so a lot of us are going to be given credit for managing the system when, in fact, it was completely beyond our perceived control because of the cycle's improving phase.

Over the long term, there has been a tremendous capital shortage. You've seen a lot of carriers jumping into the managed care business, throwing in hundreds of millions of dollars, trying to manage health care. For the most part, they're doing a very poor job of it, but they continue to throw money into the seemingly bottomless pit. We're going to run out of money; there isn't going to be enough capital to develop sloppy managed care. So, in the long term, we're going to see people making a clear decision as to whether they really want to manage care or just talk about it. Lately, I have been using an illustration with my clients who are trying to manage health care by referring to a can of Right Guard. I ask: "Do you have this little can of Right Guard that says managed care on it and are you are going around your room spraying it, or are you actually out there managing health care?" What I see in the insurance industry and a lot of the HMOs is a lot of cans of Right Guard. I really don't see people trying to manage health care as aggressively as it can be done. The blurring of the insurance lines isn't making it any easier. Carriers are developing managed care indemnity products but they are bringing their Right Guard with them. The HMOs are trying to develop open access products, throwing away some of their control and grabbing some of that Right Guard. I think that in the long term it really comes down to one big issue and that is, whether we are really willing to control the health care system. In other words, are we willing to accept HMO medicine or managed health care medicine as an acceptable standard of life? I believe the employers are demanding this, and as HMOs and insurance companies approach managed health care, if we don't accept the issue of what the employers really want, we are just going to continue going up and down the cycle like a roller coaster into perpetuity, or as long as we have enough money to continue that process.

To show you the concern of the employer market, just this week, in Seattle, the local health care coalition, the Health Care Purchasers of Puget Sound, are making a decision as to whether they will actually develop an employer initiative managed care system. We work with a lot of managed care systems and I've never seen the thoroughness and intensity of trying to manage health care as I am seeing from this particular group of people. If it's going to be successful, it will have to have tough management. They have recruited tough management. If they can get the employer community to just make the final sign-off, which I believe is about a 90% certainty, they are going to move approximately 55% of the insured population in the greater Seattle area into an employer-run program. That means, half a million of your insured population will no longer be covered by you. They are moving out of the HMO environment and they are moving out of the carrier environment because those environments are not taking managed health care seriously. In the HMO world we've often said, "What starts out in the West flows across the country." I'm from Seattle, so I'm interested in what's going on there. We're getting major employers like Boeing, and major high-tech companies, making commitments to this kind of an organization to move business into this new kind of a program. That should get your attention.

The regulatory environment is hurting profitability. In some states you have one regulation for HMOs and another regulation for insurance companies. You

also have a new regulation for exclusive provider organizations (EPOs), and a new one for PPOs. Basically there are four different situations going down four different paths and it's very difficult to try and integrate all of these together. Our long-term profitability is going to be much worse if we don't get the regulatory side enhanced. Some insurance departments don't even know what it means to capitulate a primary care physician and yet other divisions that manage the HMO, for example, think it is a fantastic idea.

In conclusion, I'm convinced that the people who learn to manage health care will be the winners. The volume getters will be the winners. They will have a greater chance of winning even if the margins are slimmer. The adverse selection managers are going to be winners and, frankly, if you're winning on all three of those areas you're going to be doing a lot more business.

We mentioned the uninsured. State Insurance Departments and State Health Departments are looking for winners in this arena right now. I was in Vermont last week talking with the people about how they plan to set up their uninsured program. They're not wanting carriers necessarily. They're not wanting HMOs. They're wanting winners. Essentially, our publics are looking for coverage for the uninsured and unless we figure out how to do it, the long-term cycle is going to be one of frustration. If we don't manage it well the prices are going to be too high and no one's going to buy it. If the employer doesn't pay for it, employees surely won't. So, we're going to be pressed from all corners. I'm optimistic for the short term, but we need to integrate some of these things into our actuarial science so that you might think of it as a blending of some of our behavioral sciences and some of our medical science, with the actuarial science. Without that, I don't think that any of us will have a very bright future.

MR. JOHN A. HARTNEDY: When someone talks these days about the profitability of individual major medical business, your first observation will be, probably, well that's a contradiction of terms. The next thing you might expect to hear about would be things like provider greed, cost shifting, trends, utilization, and AIDS, but I'd like to tell you that at Golden Rule these are our minor problems. AIDS, for example, cost us less in claims than headaches. Let me give you a real headache, a migraine, that we are dealing with. That headache is inconsistent, and often arbitrary, state insurance regulation. They have been pounding on us for years and sometimes the only way to get rid of this migraine is to remove yourself from the source of the problem, which is exactly what we have done in the State of Massachusetts.

We are not alone in our feelings. Look at how many companies are involved in the group insurance market -- hundreds. Now look at how many are involved in the individual major medical market. Nationally, there are three. If you can, think back twenty-five or thirty years ago, as to how many companies were involved in the individual major medical market. There were such companies as Occidental (now Transamerica), Lincoln, Prudential, Metropolitan, and New York Life, and the list goes on. Where are they now? Now there are only three national companies. One of those three sells only to discretionary groups. Why? They avoid state rate regulation. At Golden Rule we maintain that this abandonment of the individual marketplace is the result of onerous, unfair, arbitrary state insurance regulation. How can I say that? It basically comes from executives who have spoken to our President, Jack Whelan, at the Executive Round Table of the ACLI. The key and sometimes only reason for getting out of the business was the problem of dealing with departments of insurance regarding rate filings. Some of these chief executives of the companies I've

already mentioned said to Jack: "I admire Golden Rule for what you are doing in the major medical field, we had to get out of it" or, "How do you get your rate increases?" or, "How do you convince a board of directors to take the risk of not getting needed rate increases?" Simply put, the Lincolns, and the Prudentials, had better things to do with their capital than to invest it in fighting with state insurance departments. If the Department of Insurance was going to put such a crunch on those companies, they decided to get out rather than risk not getting the rate of return that they needed on the particular product. One large company told Jack that in Florida they backed down on the requested rate increase in order to get what they wanted on the life insurance side.

Is this shrinking of suppliers a problem? Well if you don't think the offering of individual major medical insurance is important to society, then it isn't, but actuaries, there are 37 million Americans out there who do not have health insurance. I believe this problem is due, at least in part, to lack of marketing effort. When was the last time you were walking down the street or in a mall and saw a sign that said, "Get Your Individual Major Medical Insurance here?" You might see a sign for automobile insurance, homeowners, or life insurance. There are hundreds of companies selling that, but only three national companies are selling individual major medical. The fewer the suppliers, the more headaches those suppliers have, and the less marketing you are going to see. So, primarily, it's Golden Rule and Time as the only national companies left to forage for business in the land of individual major medical insurance.

Our complaint is the same as these other companies. We have found that even though states may have adopted the NAIC standards, it is no guarantee that they are going to follow them. I only came to Golden Rule within the last year and I can honestly tell you I am genuinely shocked at the cavalier attitude that states take to the NAIC guidelines. In fact, in some states, there are no standards, no published guidelines. Justifiable rate increases are just denied out of hand. I would like to tell you about our experience in a few states.

Pennsylvania -- writes to us with questions. We respond promptly and they tell us the response will go to the bottom of a three-month backlog. Then, they may have another question on our response, and so the cycle goes.

North Carolina -- has written us five letters on our July filing, none of which have asked us a question about our deteriorating loss ratio which is, of course, why we want the rate increase.

Massachusetts -- We filed on March 4. We have sent consultants. Our CEO has talked to the Commissioner and written to him. We have spoken to legislators. On October 19, we finally got written approval of less than what we asked for in March. Our annual trend right now is running at 33%. We've stopped sales in the State of Massachusetts. We've non-renewed our $100 deductible plan.

South Carolina -- took so many months to act on our requested increase, that we began to non-renew our $100 deductible plan in South Carolina. The complaints poured into the department. The Insurance Department called us, and our requested rate increases were approved in approximately two weeks. We then went back to those policyholders and offered them a replacement policy.

Connecticut -- didn't even respond for months, and then turned the rate increase down. Our CEO with of course the "minor" cost of outside counsel, and the "minor" cost of consulting actuaries, has made two visits to the department.

Last Friday, they finally approved most of what we asked for, only seven-and-one-half months later. We've invested thousands. I probably should say hundreds of thousands of dollars in consultants, management time, and lost revenue.

West Virginia -- has said, "Please wait for more experience." Of course, we only had $60 million of earned premium on the particular product they were talking about.

New Mexico -- "take 8%, not 15%" on a product that is running loss ratios 20% above what we filed for in the first-year experience and 71% above what we filed for in the second year.

Kentucky and Iowa -- say, "only 30% a year." Our trend alone is 33% a year.

Of course not all states are this bad, but far too many are. This year we have filed for increases on nearly $20 million of monthly premium. A one-month delay costs us millions of dollars in foregone revenue. In March, we filed for an increase to be effective May 1, we finally took it September 1, and we are still waiting for six states to approve the increase. In July, we filed for an October 1 implementation date. We finally implemented November 1, and less than half of the states had approved by then. We are still waiting for twelve states to approve. I very roughly estimated that if we could have implemented our increases when we had the figures that met NAIC guidelines, we could have generated another $15 million of annual revenue.

It is very clear to me why our CEO, Pat Rooney, says we could be profitable in the individual major medical business if it weren't for the onerous, unfair, and arbitrary decisions from state insurance departments. What has happened here is that state governments have decimated the market for individual major medical insurance at the same time that the Federal Government and some congressmen are complaining that we are doing a poor job in this marketplace. We are doing a poor job. We are not meeting the needs of the public. Two or three companies servicing the individual major medical market are clearly not enough.

The state insurance departments have used the law to enable them to steal an advantage for their policyholders. By using delays, and by not approving the rate increases, they force a company to cover its losses in that state by taking money from the citizens in other states. Not only is that hard on the companies, I believe it is morally wrong. We want standards such as the NAIC standards, but we want states to adopt them and live by them so that we can have a chance to work and our customers can have a chance to buy, in a stable market. Instead, we have departments that are going to do what they darn well please, regardless of the NAIC standards, and they are going to do it differently and that is not for the good of the country. Because of that, one of our concerns, as was mentioned before, is that of the Federal Government deciding that the market is so badly served that it should supplant the insurance industry or mandate that employers purchase insurance from a small list of approved insurance companies. The comment about a "small list" was in one of the early drafts of the Kennedy mandate. We'll either have national health insurance or there will only be a small number of companies approved to participate in the mandated health insurance market. The rest of us will be out. The out includes small businesses. By requiring health insurance the Federal Government will be, in effect, condemning smaller companies that can't afford additional labor costs. This is a serious matter when you realize that 35% of the new jobs in 1988 came

from businesses that employ 1-19 people. These are the companies that will be hardest hit by mandated coverage. This action on mandated health insurance may have no effect on the individual major medical market, because employers may very well start cutting back the hours of their employees to keep them below 17.5. These people will be working two and three jobs to earn income. They may have a decent income, but they'll have no fringe benefits, so they'll still have to go out and buy individual major medical insurance.

The major problem that we face is state regulation. This camel of state regulation only has its nose under the tent now. Just as an example, it is mandating coverage which is driving up costs, in some cases to the point where small employers or individuals on the street cannot afford their insurance, and it is defining what your groups will be that you may sell group insurance to. Profitability for the individual major medical market is gone for 1988, but I believe 1989 will be a turnaround year and I hope it will be profitable thereafter. It will depend on a couple of things, either the states do pass guidelines that we can all live by, or that we start pulling out of the states that won't play by the rules. Therefore, you need to work on good NAIC guidelines -- you need to see that these guidelines are passed in the states where you have access to the departments and to the legislators -- and then you need to fight to see that the states follow these guidelines. For at least some of us, if not all of us, it's just a matter of survival.

MR. DAVID L. BAXTER: I'll be talking about the individual non-cancellable disability income market. First, I'd like to talk a little bit about some of the empirical research that we've done on the industry's performance. Then we will make some scattered observations from discussions with insurance executives in working with clients, and finally I will try to relate this to strategic implications for companies that want to be in this business in the future.

To put this industry in perspective, the individual disability market amounts to approximately $2 billion in premium -- about 2.5 million policyholders. This compares to the life insurance market with $60 billion in premium, Group LTD with 20 million covered employees, medical care with 180 million persons, or dental insurance with 100 million people. Our 2.5 million individual disability income policyholders would have to be described as a relatively small market.

This market is not as fragmented as many segments of the insurance industry. The top three companies control just over 40% of the market and the top 20 companies control about 85%. So, you're not talking about a lot of players here, compared to the medical business or the life insurance business. Over the last five to ten years the industry has shown some very healthy growth, averaging just over 15% annual growth in total premium. Notwithstanding that, there have been some very high competitive pressures throughout this period that companies have had to overcome. I believe these pressures have come primarily from their distribution systems, their salesmen. Pressure is not yet coming from the actual consumer, but still, it's there. The industry has what I call a high trouble index. When I ask somebody how they are doing in this line of business and they say -- "well, we think it's fixed" or "we think we have to fix the underwriting" -- I know the trouble index is a little high. The more you hear the word "fix," the higher the trouble index and I'd say there is about an 80% trouble index in this business. Those of you who are marketing it should think about that and think how many conversations you've had about it without using "fix."

Several companies have been able to make fairly steady profits over the last five to ten years. There have also been some big losers. The total of all that is, at least up to a couple years ago, that the industry had pretty much waivered around break-even on a statutory basis if you combine all the companies, or used our studies which look at the top twenty companies with 85% of the business. However, the latest studies have shown that in the last two years profitability has been significantly reduced -- 1986 showed about a 5%-of-premium loss and 1987 showed about 8% loss. I guess the only thing this line has in common with the medical business is that 1987 was the worst year in history for this particular market. Of the twenty companies we looked at during the last five years, seventeen showed deterioration in profits. Of those twenty companies, nine never had a gain in any of the five years. What has happened in the last couple of years is really not a short-term effect, but more of the convergence of several trends. One of these is an increase in expense levels, driven primarily by marketing. Expense levels have increased by about 5% of premium in the last five years.

Claims ratios have shown a fairly steady increase, about 1.5% per year over the last five years. Finally, a small impact, but worth mentioning, is that investment income is just not as high as it was at its peak a couple of years ago. I think recent results are more realistic, but in fact, may be even still a little too high. That accounts for a percent or two drop in profitability.

The conclusion of all this is that although we're seeing an industry that has lost a lot of money, I don't believe we're seeing a phenomenon that's totally out of control. We don't see any real evidence of a major deterioration in claim levels. These results are more, I believe, the result of a fairly systematic and steady process of management decisions which have gradually eroded the profit margins. These decisions were in price reduction, increased benefits, and higher marketing costs. I think there's some good news here in that I don't believe there's anything we've seen that says it can't be turned around. Now, that doesn't mean it isn't difficult to turn around. Again, it's a highly competitive environment. There are a few companies that really lead and for the most part, companies look around to see who's doing what before acting. They would really like to see somebody else go first in the form of price increases or cutting back in benefits. Changes tend to come somewhat slowly. In the last six months to a year, we have seen evidence that there are price increases coming, and some product deliberalizations but, again, it's happening very slowly.

Another aspect is that it tends to be a very volatile line of business. The magnitude of one claim can be very high, for say a lifetime claim, to a company that might have $20 to $50 million in premium. So, it's very difficult for a company to know at any given point in time just how well they really are doing. If the results are poor, are they real or are they just a statistical fluctuation? This causes companies to react a little slower. For those of you who have seen some poor results in the last couple of years, let me assure you you're not alone. It's not a statistical fluctuation, the industry on the whole, which is a $2 billion block of business, is fairly credible and it says that claims, expenses and overall profitability have deteriorated.

Now, what does this mean for companies wanting to be successful in the future? I tend to be optimistic for the business, even though I was somewhat surprised to see results over the last couple of years being so poor. It takes a real commitment to this line. You need to have a good management information system but even as important, I think, is to listen to your claims people. They see

the problems before anyone else. You have to temper that, though, with some empirical data because the claim's people have no way of relating the level of claims or the number of claims to your actual block of business. Actuaries have to do that. It is very important that this information be given to the underwriters and the product developers so that the decisions they make can take into account the most timely claim information.

Marketing is very important. This is probably the biggest source of my own continued optimism for this line. I think there is still a lot of room, given the size of the industry, and the number of players, for some real marketing. I'm not talking about adding a bell here and a whistle there for your sales force, I'm talking about really identifying market segments and driving products into those markets. I think there's a lot of room for that, and any company that can't somehow find a segment to work in is going to be forced to compete on the basis of every other company out there with product features and reduced price. They will probably have to count on some amount of steady erosion in their profit margins. Distribution is also important. If you don't have a distribution system that can get this product to the consumer, you can't distribute this product. It's very difficult without access to salesmen who can market this product.

There will continue to be competitive pressures. The product has a very high strategic value despite its small size numerically. It is strategically very important to a lot of companies to help support their sales forces, and to help train them, and for some companies it may be the only product, or the only significant product, they have. Prices, in my own opinion, are not high enough. I can't stand up and say everyone should raise prices, but I believe that competition in areas other than price could be very helpful to this line. There are a lot of companies that really don't know they don't have a handle on the true expenses of doing business in this line. I think it's very important that companies do get a handle on that and pick a level that they can live with and manage. Again, that's part of the overall management of the business.

Any company wanting to do business in this industry has got to make a full long-term commitment. You can't be half in this business or half out. It takes a 100% effort to do whatever is required to maintain the profitability you are looking for, not to overreact in the short term, and to maintain a long-term posture. I think if a company can do that, a company is going to be profitable in this market.

MR. ALAN N. FERGUSON: David Axene referred to a turnaround or a change in the level of trends. I guess he is suggesting that they are not going up as fast as they were. We've not seen any evidence of that. Hospital costs seem to be increasing. We've noticed an upturn in the rates. Physician costs have been coming down but in balance I think rates are going up overall. I have a question on the Puget Sound Employer Coalition. What is it they are trying to do with the managed care system?

MR. AXENE: First of all, the cycles are very local and so I was referring to sort of a global thing from what I've been seeing at various places in the country. Each area has a different timing of the cycle but the underlying patterns of the cycle seem to be turning around. What you see from a carrier point of view is slower because of the way you measure things, but I would say it could vary one way or the other by six to twelve months from where it's really going to turn around.

Now for the things that the Puget Sound people are trying to do: The larger employers want self-funding, or ASO, or some kind of paying their own experience type program. Within the managed care environment in Seattle, very few plans are willing to do that. They believe that managed care is important but they want it on their terms. Essentially, what the organization is doing is creating an unregulated, self-funded, managed care system. It has very, very tight protocols on the inside of the system for both ambulatory care and institutional care. These are all on paper right now, with people who have the abilities and the expertise to carry it through. There is to be a decision this week on whether they will go ahead or not, but everybody is leaning to go ahead. I see them taking it very seriously. There will be no 800 number, and there will be utilization control methodologies. We're talking about daily visiting every patient who's in the hospital. A very serious health care management style.

MR. KENNETH S. AVNER: My experience is that employers will talk a good game but when push comes to shove they back down. On the carrier side, we would prefer to have the employer take managed care seriously. The problem is that employers often just won't have anything to do with it. I guess I'm skeptical that whatever they say now is really what is going to happen in practice, although, we'd welcome it.

MR. AXENE: Before I met with them, I would have agreed with you because I have never seen an employer initiative work in quite this same way. I'm taking these people very seriously because of the detail of their effort to date. It is more intense than any HMO development I have ever seen.

MR. MARK E. LITOW: One thing that I've tended to see is that the outpatient utilization is much higher, as opposed to the charge levels going up. A second thing is that within that realm the trend is probably coming down. A problem I see from the hospital side is that hospitals are really squeezed, because they are now losing money on Medicare besides losing money on Medicaid. Since the HMOs have somewhat of a control on what the overall fees are going to be, the private pay sector is really getting clobbered. If that's the case, that means that the utilization of the outpatient feature will stay high, even if it does come down somewhat. How are the hospitals going to make it in the long run under that scenario?

MS. NIEHUS: The first part of the question had to do with outpatient and, yes, we've seen enormous increases in frequency as well as in average charge. When we looked at the numbers comparing 1987 to 1986, we found inpatient costs going up 2-3% a year, and outpatient costs rising at over 30%. A lot of that is frequency. We've seen that even though the inpatient utilization continues to go down, the charges are going up pretty rapidly. I think there are a fair number of hospitals going out of business. The ones that are staying in are passing a lot of costs along.

MR. LADLEY: The inpatient utilization has shot up but the inpatient hasn't changed at all as might have been anticipated. In this sector, I think inpatient costs have been rising very rapidly, as well. Overall, I don't see the kind of trend slowdowns that are being discussed here. In the type of business I was talking about with the very large trends upwards, you have some impact of the underwriting effect as well, so that you have to factor that in well beyond any kind of trends.

PANEL DISCUSSION

MR. HARTNEDY: I was at a session recently, sitting with a couple of hospital administrators, one from St. Vincent's in Indianapolis, and one from Humana. St. Vincent's was talking in terms of 80% occupancy. They were operating profitably this year and that all sounded quite reasonable to me. The comment from Humana was that their occupancy rate is running at approximately 56% and yes, they too are profitable. Think of the cost that they have to be transferring to keep a 56% occupied hospital profitable. You know what kind of costs we are paying for each individual that's going into those particular hospitals.

MR. AXENE: I would like to make one comment about the trends you are observing. If you unwind the impact of adverse selection, both on the individual side and on the small group side, you'll find that your real trends are a lot less. The issue becomes one of trying to quantify the impact of adverse selection. This is a very difficult process, but I've seen estimates that from 5% to 15% of the trend rate is merely a maldistribution of typical conditions. You may be seeing a leveling off of underlying trends but you may be seeing, on top of that, worsening adverse selection. So, if you just look at the global area completely combined you think your trends are still up, and what's really necessary is to try to unwind the various components.

MS. JOAN P. OGDEN: I did an analysis on a very large block of employees, using primary care physician services. The average cost in the last year for office visit services had gone up only 7%, procedure by procedure, but the average cost per encounter had gone up 23%. No longer were brief and limited office visits occurring. They were extended and intermediate and comprehensive. I think we're seeing a real creep in terms of physician determined bottom line income.

MR. TRINDLE: I think that reinforces what David said about the managing of health care getting to be more of a battle.

MR. ANDREW M. PERKINS: Mr. Hartnedy, you talked about your trend factors and rate increase filings. It sounds like you are filing for increases in the neighborhood of 30-40%. Do you feel you can increase rates that much on individual contracts and not drive away so many healthy policyholders that it becomes counterproductive?

MR. HARTNEDY: No. We're trying to spread some of our increases out over the year because basically your summation is right on. We have taken some increases earlier this year, we've taken some later this year, and we will be taking some in the early part of next year. We are taking our largest increases on our $100 deductible plan which has, by far, our highest loss ratio. In some of the states we have begun to non-renew that product and offer a $350 deductible in place of it. I really do not think we can recover the $100 deductible market on a profitable basis, simply because of what you just said. The rate increases would be too large and we would drive away the healthy lives and the business would do nothing but deteriorate. Basically, we're going to move people from $100 deductible to a $350 deductible and they will see very little reduction in their premium, which means obviously they are taking a rate increase. That's one of the ways that we're addressing the problem. The other way is to try and spread the increases out and see if we can do this about every six months. That, by the way, is also a problem in a number of states that only allow you to take one increase a year. We have visited one of those states, Arkansas, and they were very receptive to us and I think we had a very successful visit. They could see our point and the meeting went well, but one

increase per year right now just isn't going to cut it. Prudential had this experience a few years ago. They were taking one increase a year on their CHIPS program. I understand they were filing for increases in the 40-60% range. By company practice, they were doing one increase a year, they wanted to change that and take them more frequently, but various states would not let them back off from their normal company practice of one increase a year. Of course, the business was just decimated. Earned premium plummeted even with the 40-60% increases, which will give you an idea of how much the lapse rates went up.

I would like to add a comment on what Dave just said about trend. In the 33% trend that I gave you that we're experiencing, we have tried to remove part of the selection. That is not a totally pure number. I say that based on the fact that we did our initial filing anticipating loss ratios of 48% first year, 53% second year, 58% third year, 62% fourth year, and 65% thereafter. That's how we anticipated selection would wear off. We're a tough underwriting company and our selection is wearing off very rapidly. The curve is very, very steep, in fact it is much steeper than what I just described to you as contained in our original filing. The 33% trend is what we got out of that. So what I'm saying is, that not included in that 33% is the change from, for example, 48% to 53%.

MR. JIN-DIH SHIH: I think that for the last couple of years we underestimated the trend and then when it hit us we were surprised. I tried to get some idea of how and what happened because the trends jumped up so high, in that we had assumed 10s and all of a sudden it became 20s. Maybe we can blame this partially on the government because of cost shifting, but another possibility is that the providers are finally catching up with our cost-containment program. For example, one of the comments was that individual procedures went up only 7% but combined, they went up 23%. What I heard is that it used to be a simple 15-minute office visit, but now it's intermediate and complex because somehow they have to get their bottom line.

Another possibility I was looking at is the inpatient/outpatient shifting which basically generates a lot of increase in the trend for outpatient. It used to be that for a tonsillectomy you would stay in the hospital for two days. Now you get a pint of ice cream and go home. This transfers the bill for whatever the expenses are on that to the outpatient where it will push the trend up.

Another possibility is that doctors have to adjust their income towards the end of the year. Their CPA told them to bill before Christmas instead of waiting until January. I don't know how much that impacts, but when you look at the year before, it's possibly 10% lower than normal, and you could envision the last month in the current year as 10% more than normal. This would definitely give you a very adverse, misleading trend.

MR. HARTNEDY: I wouldn't challenge anything that you said about trends. I think they are hard to define. I think utilization reviews are very good ideas. I do not think that they are fully working. That doesn't mean I recommend that we drop them, but I don't think that they're fully working because there is a fear of law suits when you go through utilization review. Let's keep up the practice but I question its full effectiveness. Another thing that we have found is an increasing number of claims per policy. Within about twelve months, we have gone up from about five claims per policy to over seven claims per policy. The average amount of that claim has not increased much, but it has gone up almost 5%.

PANEL DISCUSSION

MR. AXENE: Along the lines of working with a physician vs. against him, I have a slightly different opinion; I think that we've been working with them too much and not holding them accountable. It may be that until we actually start holding them accountable we won't be able to see the managed care advantages that we want to see. Whether we are using kid gloves or boxing gloves, I think that sometimes we need to use them just a little bit more aggressively. Maybe that would help manage care better.

MR. LADLEY: Pharmaceuticals is one factor, although a relatively minor element, of the change. The gaming of physicians is another, and one which somebody reasonably flexible and fast-moving in the business will be able to handle best. You can set out the very best of systems, but when the doctors are as bright as they are and as good at gaming as they are then you're going to have a real problem any time you set out a system and let them operate on it. There's almost confrontational claims administration and managed care coming up, now, and there are organizations having some impact by teaching both doctors and hospitals how to do that kind of gaming. Clearly there is a fair amount of hospital cost shifting, and there's some aging overall, and I'm not sure that anybody knows how to identify their trend vs. some of the many things that have happened in the extreme, such as falling behind in the rating process and giving excessive discounts for cost containment and for the privilege of underwriting various controls into the product design.

Something that hasn't been mentioned here but which clearly has an important impact is the cost of monitoring all this and dealing with it. Things have not gotten simpler by any means and we have not only the morbidity side but the expense side, as well, to consider.

MS. NIEHUS: One of the things that we lost sight of as far as being able to manage care were the gains that were made in hospital utilization. We have to give a lot of credit to Medicare initiatives in teaching the hospitals to work more efficiently. We got a lot of those gains but it was basically a ratcheting. It brought us some savings, with an underlying trend still continuing and when those savings diminished we really started to see the trend turn around. That's another factor that, I think, blind-sided us a little.

MR. HARTNEDY: I liked a couple of the comments about really facing up to the issues. I think we have to get tough with some of the people who we deal with. If you have the facts, and you have the information and you know what has to be done, you must be willing to act. If somebody won't cooperate with you, as in the example of the states, you must be willing to bail out. That's tough stuff, but your companies are losing money in these lines. There can very well be other alternatives but you've got to be willing to be tough.

MR. LITOW: I've worked with several companies that have had a tremendous amount of trouble with the states and they haven't backed out. They probably should have. For instance, there are states that John didn't even mention that are worse; Georgia's on a six-month backlog of rate increases. You can't do anything there. Generally poor state cooperation is one of the main reasons why individual major medical is having so much trouble. Part of the problem is that the states just don't have the expertise or the manpower to handle this regulation. They have contract analysts looking at things from an actuarial perspective. That must be corrected. We also have a number of states that will not give rate increases until after the election because some of the commissioners are

going through an election process. A couple of companies that I worked with can't get a rate increase until January 1, because of that.

MR. TRINDLE: Barbara tells us that the MET marketplace is still a difficult one and going through a lot of innovation. Jack told us that there is a lot happening in the TPA environment but basically there is solid value and a good business process going on. David Axene says that the HMO and the managed care environment need better management. Individual medical has a major regulatory problem and I agree with John that actuaries can do something about improving the process by getting involved and by hanging tough. Dave Baxter told us that though profits have been deteriorating in the non-can disability area, there is hope, and opportunity, for creative marketing.