RECORD OF SOCIETY OF ACTUARIES
1990 VOL. 16 NO. 1

INDIVIDUAL DISABILITY INCOME -- MANAGING THE BOTTOM LINE

Moderator: W. DUANE KIDWELL
Panelists: ROBERT W. BEAL
DAVID E. SCARLETT
LOIS A. VANDE KOPPLE
Recorder: W. DUANE KIDWELL

- Underwriting
- Claim control
- Product design
- Sales tactic
- Management reports
- Reinsurance
- Closed block strategy

MR. W. DUANE KIDWELL: The ranks of individual disability income underwriters are thinning out. There are too many company casualties. The health of our industry simply must be improved.

The bottom line has been deteriorating steadily for the last ten years, even as it has been absorbing increasingly generous allocations of surplus investment income. The last four years have shown heavy statutory losses in most companies, including two of the four largest disability income carriers. Clearly, we must do a better job in managing the bottom line. Our panelists will discuss some of the necessary ingredients of sound management as they see it from the perspective of the outline topics.

MR. ROBERT W. BEAL: My assignment is to discuss the impact of product design and sales tactics on the bottom line. I have combined the two topics and broadened the subject just a little under the more general label, marketing.

My present job is Finance Officer for the individual disability division in my company. Consequently, I often find myself pitted against the dreaded marketing department and its evil henchman, product development. They march, under the banner, "Any Sale is a Good Sale," while I stand guard over the sacred, but delicate, and many times elusive, profitability.

If the truth be known, the marketing department does worry about the bottom line. Its marching orders can be boiled down to this: Get profitable business and get as much of it as possible.

The two objectives, premium growth and profitability, are often viewed as mutually exclusive or negatively correlated, if you will. And they are, if marketing tries to generate a high volume of sales by way of the most liberal products, at the lowest prices, with the highest commissions, and with the underwriters on extended leave. But this

need not be the case. Premium growth and profitability can go hand-in-hand if certain fundamentals are in place and management's growth targets are realistic and have a long-term perspective. Let me touch upon premium objectives quickly and then turn to the fundamentals afterwards.

Premium growth should be measured in terms of total direct premium not just new business. It doesn't help to have strong sales if the old business is not sticking. The appropriate premium growth target depends upon many factors including the size of the block of business, its market share, and how experienced the field force is.

Any management goal to dramatically increase premium overnight should be achieved through acquisitions or block reinsurance. Dramatic increases in new sales should be attained through adding new co-marketing or private labeling clients. Stay away from wild swings in underwriting requirements and big premium discounts to generate new sales. They are like fish hooks. They go in easy, but they are very messy to pull out.

The product we sell is not just a contract and premium. It encompasses the quality of your field force, field compensation, your underwriting department, and your customer service orientation, in addition to the contract and price. These are the fundamentals I referred to earlier. Profitability is dependent on all of them. A significant deficiency in any one will likely steer business away from your company, or it will put too much pressure on the other factors to compensate. In other words, you will then need bigger discounts, more liberal products, higher commissions or more liberal underwriting requirements. Not surprisingly, profitability will suffer.

Let me say a few words about some of these fundamental aspects of a profitable product.

First, it should be no surprise to anyone that the experience of your field force in selling disability coverage, or how well it is established in a geographic area, can have a big impact on profitability. Sales expectations must realistically reflect this. The green agent or broker will be more focused on keeping his/her head above water and far less on quality. However, the more experienced and established field force should be expected to be more selective and practice better field underwriting.

Second, I seldom hear of good brokers refusing to do business with a company just because the underwriting department is not the most liberal in the industry. What they value is knowledge, experience, consistency, communication and timeliness. They want to be kept abreast of the underwriter's progress or questions. They may respect an underwriter's adverse decision, but it will be much easier to accept if the underwriter is able to sell his or her decision, and brokers will appreciate it even more if adverse action is accompanied by an alternative offer initiated by the underwriter.

Next, your customer service orientation, particularly service to the broker, must be at least in line with the competition. However, your company will win points if it projects responsiveness, timeliness and a sense of urgency with respect to brokers' needs.

If management has succeeded in appropriately addressing these fundamental areas, then there should be far less pressure on your products, commissions and rates to be the most

competitive. You do not need every bell and whistle in your product portfolio. My company offers an open-ended recovery benefit in one contract. Most of our competitors do not. However, your portfolio must have certain standard features. You cannot compete without offering such features as noncan, total disability, own occ, residual, cost-of-living riders, lifetime sickness riders and a few other basic things.

Few companies are able to be strong in all these fundamentals. However, it is essential to maintain at least a minimum acceptable standard in most and some obvious strengths in a few. Make sure you train your field force to know and sell those features where you are the strongest.

One factor that I have not discussed yet, which could undermine everything else, is the inherent profitability of the markets in which you choose to sell. If your best field office is sitting in your worst state, you have a big problem and a big decision to make. If 25% of your new sales is to an occupation that is no longer profitable, you have another big problem and inevitable decision.

It is critical to your company's future profitability in this business to have the MIS tools to segment your market into areas that are profitable and those that are not. Then you must be willing to make some very hard decisions to steer your field force away to the unprofitable segments and to the profitable. Your rate structure should be designed to support these decisions.

I hope my main point was clear: that Marketing and Product Development must be just as sensitive to profitability as is the Finance Department. They must deal with the "whole" product, not just the contract and price. And lastly, they must be willing to make painful decisions when it is clear that old strategies are no longer profitable.

MR. DAVID E. SCARLETT: I would like to talk with you about both underwriting and claims administration with regard to disability income products. Since I'm an actuary and not a medical doctor or underwriter, my comments on physical underwriting will necessarily have to be fairly general, but I will talk about AIDS, geographic variations in experience, applications, financial underwriting, and the need for good control and communication.

Those of you who are familiar with the individual disability industry know that profits have deteriorated over the last few years. In the most recent issue of the *Disability Newsletter*, there was an article which studied the financial results of the top 20 writers of individual noncan disability from 1983 through 1988. Table 1 shows that these 20 companies, taken as a group, have suffered statutory losses in all six years, even after including investment income on reserves. The trend shows the problem is worsening, going from a loss of 0.1% of premium in 1983 and 1984, to a loss of 12.9% of premium in 1988. We don't yet have all the data for 1989, but we hope to update this study through 1989 for the next issue of the *Disability Newsletter.*

Most companies seem to have reacted to these losses by tightening their underwriting, and many have also increased their prices. The underwriting tightening has been

TABLE 1

Non-Can Disability Financial Results

	1983	1984	1985	1986	1987	1988
Premiums	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Net Investment Income	20.8	22.1	22.7	21.8	21.8	22.9
Claims Incurred	63.2	63.0	63.5	67.4	69.8	78.0
Expenses	57.7	59.1	60.2	61.2	61.8	57.9
Gain from Operations	-0.1	-0.1	1.0	-6.8	-9.8	-12.9

accompanied by dramatically increased blood testing to help protect companies from the AIDS menace, and the blood testing has been accompanied by more urine testing and paramedical exams. Underwriters are being asked to get more attending physicians' statements (APSs), order more personal history telephone interviews, get more income verification data, and in some cases, more commercial inspection reports and more motor vehicle records.

All of this has put much more pressure on the underwriter. He or she has a tougher job than ever before walking the fine line between company profitability on the one hand and sales and service to the distributors on the other. The underwriters are taking longer to get all this information, and are making more adverse underwriting decisions because of it. More policies with ratings and rider exclusions and more flat out rejections result.

Thus, the underwriting department is more than ever being thought of as the sales prevention department, and in many companies, the pressure and complaints from the marketing and sales people are very strong. It is my opinion, however, that this increased underwriting vigilance is just what's needed to help turn profits around.

Table 2 shows the AIDS disability payments of one of my clients, and the pattern seems to be fairly typical of many companies. There was very rapid growth of AIDS claims and

TABLE 2

AIDS Disability Payments
as a Percent of All Disability Payments

Year	Percent
1985	0.4%
1986	1.8
1987	1.7
1988	4.3
1989	4.4

benefit payments from 1985 through 1988, and a somewhat slower rate of growth in 1989.

As I have already indicated, companies responded to the threat to their profits by instituting an aggressive program of blood testing. Most companies are testing at a benefit threshold of $3,000 per month, and some have more stringent requirements of $1,500 or $2,000 per month in the problem states of California, New York, New Jersey, Florida, and the District of Columbia. Some companies also have lower testing thresholds in Texas and Georgia. Table 3 shows the AIDS testing practices of the top seven writers of noncan disability, as described in the latest issue of the *Disability Newsletter* which was published November 1989, so some practices may have changed since then. You can see quite a divergence among these companies, with one major writer routinely testing only at $3,500 per month in only three states: California, Florida and New York.

TABLE 3

AIDS Testing Practices

Company	Nationwide Threshold	Problem State Threshold	Problem State
1	$3,000	$2,000	CA, FL
2	3,000	2,000	CA, FL, GA, NY, TX, DC
3	2,501	1,501	CA, FL, NJ, NY, TX, DC
4	3,001	2,001	CA, NY, DC
5	None	3,001	CA, FL, GA, IL, MA, MD, NJ, NY, PA, TX, DC, PR
6	3,000	None	
7	None	3,500	CA, FL, NY

One of the great benefits of all this testing is not just protection from the AIDS risk, but also the ability to detect the use of illegal drugs, such as cocaine, if a urine sample is taken at the same time a blood sample is taken, and the ability to detect liver function abnormalities. One of my clients has been seeing a positive AIDS frequency of about 4 per 1,000 tests, cocaine frequency of about 8 per 1,000, and liver function abnormalities of about 20 per 1,000. Every cloud has a silver lining, I guess: if companies weren't concerned about AIDS, I don't think they would be discovering these large percentages of applicants who have drug and alcohol abuse problems.

With all this additional information the underwriters are getting, I think companies can financially justify testing almost every applicant that comes their way. I advise my clients to be one of the leaders toward lower testing threshold, if they are concerned about profit deterioration on their disability blocks of business.

With regard to geographic variations in experience, almost all disability writers are finding much higher morbidity in California. Several of my clients have studies which show the California claim costs to be twice as high as experience in the rest of the country. One company's analysis has shown that its California problem is primarily a

frequency problem, rather than a claim termination problem. Some companies are finding higher experience in Florida, especially south Florida, and other companies are having problems in New York and New Jersey. The one common problem area, however, is California.

The response of most companies has been to greatly tighten the underwriting of California business. Most companies have lower testing thresholds in California, as we have already noted, and two companies that I'm familiar with have decided to test all California applicants. Income verification requirements are more strict, especially at younger issue ages. Some companies are no longer offering a 30-day elimination period in California, and other companies are no longer offering to underwrite the lower, blue collar occupations. Claims people have discovered that quite a few California claimants can't speak English very well, so underwriters who are ordering personal history telephone interviews are insisting that the phone conversation be directly with the proposed insured. Motor vehicle checks are being more routinely ordered, as some companies are seeing a higher auto accident rate in California. More APSs are the rule, and lower nonmedical limits are being established in that state.

A few companies are verifying the application information with the insured, after the policy has been issued and paid for. This is helping the claims departments deal more effectively with claimants who say that they gave all the pertinent information to the agent, but the agent said that some of the information was not important enough to put on the application. Even in those situations where the insured does not respond to the company's verification efforts, the claims people find it useful that the company tried to verify and got no response from the insured. Some companies have done this nationwide for many years, while others are just beginning such a program to help deal with the California problem.

Many companies have strengthened their income verification practices nationwide, not just in California. It is not uncommon to find underwriters asking for income to be verified at benefits over $1,000 per month in the lower occupation classes, and at $3,000 in all occupation classes. Self-employed people must submit their most recent tax return, while salaried employees can submit a W-2 form, or a payroll stub in lieu of a tax return if they so desire. Some companies have made the submission of this verification optional, and in some situations will even give a premium discount to those who elect to submit it. I wonder what that says about the applicants who don't elect to verify their income and what kind of morbidity can be expected from them.

Some companies have very liberal ways that benefits can be increased after the policy is issued, and the underwriter must keep these in mind. There are automatic increases to benefits built right into the policy, as well as guaranteed purchase options which can be exercised very quickly in the life of the policy if the insured has the income to justify the higher benefit. The underwriter must watch out for the agent or applicant who is trying to get around an underwriting requirement at issue by cleverly using these post-issue benefit increase provisions. For example, this has been a common technique used to circumvent the testing requirements.

Like the underwriters, the claims people also have a very difficult job. Many times their hands are tied by very liberal policy provisions, and they have little recourse but to pay or be sued. When they do contest a claim, they must be concerned about some fairly liberal court decisions in the past, and the constant threat of punitive action damages.

The own-occupation definition of disability with a dual definition provision which allows the insured to work in an occupation and still collect full disability benefits is one reason that claims people have to pay out so much in benefits. Guaranteed insurability options where the insured can exercise a benefit increase option after he becomes disabled, and have the insurance company waive the entire premium is another reason. Unlimited return to work benefits, uncapped and unindexed cost of living benefits, lifetime residual benefits, lifetime accident benefits, lifetime sickness benefits for disabilities right up to age 65, lifetime continuation of policies, and normal pregnancy benefits are all reasons the claims people are paying out so much. It's interesting to me that so many companies have only tightened underwriting in an effort to improve the bottom line. It is true that prices have risen, but what about product changes?

Some companies have put together so-called "fraud squads" within their claims departments. These people are usually some of their best and most experienced claims investigators who have really honed their investigative and negotiating skills. With liberal products, and some fairly relaxed underwriting prior to the last couple of years, disability writers have been fairly easy targets for the less scrupulous in our society, and the claim fraud squads have been somewhat successful in dealing with them.

Rehabilitation efforts have greatly benefitted those companies that have seriously implemented such programs. It is not unusual for a rehabilitation program to save a company $10 in claims for every $1 spent on the program. So why can't we do more rehabilitation, and drive the payback down to 5 to 1, or even lower, all to the company's benefit? Claims people will tell you that there are only a limited number of candidates for rehabilitation, especially with all the dual definition, own-occupation policies in force. I understand that, but I still think there's a real opportunity here, and I'm not convinced we have fully developed it yet.

Some companies are reporting significant bottom line benefits in purchasing structured settlements for some of their existing claims, or selling some of their claims through assumption reinsurance. Their logic is that, if the claim can be disposed of for less than the reserve the company is holding on the claim, then the bottom line is improved. I would caution these companies to remember that reserves are constructed to be appropriate in the aggregate, not necessarily on individual claims. If the company sells only those claims for which the reserves were somewhat redundant, it could find that the reserves on the remaining claims are not adequate, and that reserve strengthening needs to take place. I can envision some scenarios where this strategy can actually hurt the bottom line results if the company isn't careful.

Claim departments and their legal advisors have always been very cautious about the handling of lump sum claim settlements. They usually wait until the claimant or his lawyer brings up the idea just so they don't get accused later on of trying to take advantage of a disabled person who is in a tough situation. Lately I have heard of

companies that are getting somewhat more aggressive in this area. They are verbally bringing up the idea of a lump sum settlement with those claimants who have dual-definition, own-occ coverage, who are working in a new occupation, and seem to be doing well economically. If there is some interest on the part of the claimant, then the claims people proceed cautiously, getting a written statement from the insured that he is voluntarily giving up the policy and its benefits without any coercion on the part of the insurance company. This seems like an innovative idea that I will follow with great interest.

Some claims people like the policy provision called the "time limit on certain defenses" which allows the company to contest for fraud at any time in the life of the policy. Other claims people argue that it's too difficult to prove fraud, and they would prefer the "incontestable" provision which allows any periods of disability to be subtracted when measuring the two year period during which the claim can be contested. If you haven't had this debate in your company, I suggest you do so, and let the claims people make the final decision. I would also ask the question, "Why don't we consider a three-year incontestable period, or time limit on certain defenses, which can be approved in some states?" I haven't researched it myself, but I'm told that the three-year provision is approvable in California. If so, what are we waiting for?

Accident and sickness benefits which are not coterminous can be a real problem for the claims people. Lifetime accident with two or five year sickness benefits gives the disabled claimant a real financial incentive to make the disability seem like an accident. For example, if a claimant has a chronic back problem, and alleges that a claim was due to an unwitnessed accident where the claimant fell on some ice in his driveway, the claims investigator may have a really tough time proving that it didn't happen that way. We can help by insisting that benefits be coterminous.

Here's my last comment which really applies to both underwriting and claims. It is common for both departments to need the help from time to time of an experienced accountant and/or tax person. It's been my experience that if the claims and underwriting people try to rely on the accounting or tax departments within the company, or at their reinsurer's company, they won't always get the timely service they need. I think it makes sense to hire an experienced individual, perhaps on a part-time basis, to be available to both departments at specified times. A couple companies have had very good experiences in hiring ex-IRS agents who retired early with all sorts of accounting and tax knowledge. They have the "street smarts" to deal effectively with people who are doing their accounting and tax returns in aggressive and highly creative ways, and who deal with insurance companies in a less than forthright manner.

Summing it up, we have made it tough for both underwriters and claims people to do their work, and we are now depending greatly on their help to bail us out of an unprofitable situation.

MS. LOIS A. VANDE KOPPLE: Let me begin with a brief history of how the idea of disability income reinsurance for the industry was introduced. Initially, disability indemnities were low and benefits were short term. Most companies could afford to carry the entire risk on the policies they issued. As the industry expanded to higher

indemnities and long-term benefits, many companies recognized that they couldn't handle the entire risk on all cases. Most companies initially responded by setting low issue limits, with higher participation limits, so the amount of risk that they held was reasonable for their company. As reinsurance entered the field, it allowed higher amounts of disability income under one policy. A company could retain the amount with which it felt comfortable, while offering the policyholder more adequate coverage through its reinsurance arrangement.

In doing so, though, most of these companies recognized that disability income was very different than life insurance. The amount of advice and control that was necessary in being able to handle disability income made reinsurance even more desirable for disability income than for life, so many companies opted for reinsurance on disability income even if they did not have it on life insurance.

One major purpose of reinsurance is risk sharing. Disability income is difficult to manage. The long-term benefits stretch the insurer's liability over several years. Also, many companies are finding that morbidity is greater at the higher indemnities, especially on the individual sale. Reinsurance can provide assistance in managing this risk.

Different balances of risk sharing through reinsurance can be achieved by varying retention and minimum cession. Quite often companies only think about the retention schedule itself, but the minimum cession amount can be used, in effect, to retain more and also to cut down on the expense of the reinsurance. As an example, consider a company with a retention of $2,000 monthly indemnity and a minimum cession of $500. It would keep all cases up to $2,500 and the smallest amount it would cede would be $500. With the same retention of $2,000 but a minimum cession of $1,000, the company would be increasing the cases retained (up to $3,000) and thereby lower its administrative cost for reinsurance.

In some reinsurance arrangements, experience rating might be available. This might be desirable from both the reinsurer's point of view and from the client's point of view. A client may feel as though its company may be able to generate better than expected experience, and the reinsurer may want to try to encourage good experience by providing experience rating for that company.

Another purpose for reinsurance may be earnings stability. What we're talking about is control of high indemnity and long-term claim impact on the bottom line. Coinsurance and yearly renewable term (YRT) reinsurance treaties generally cover basically the same benefit payment period as the client company. There is, however, an expense associated with having a reinsurer involved with the risk right from the start. Another alternative, an extended elimination period treaty, in which the reinsurers' risk sharing would begin say, two years or five years after benefits begin, provides long-term protection, but is a lower cost reinsurance alternative for companies that can afford to hold full coverage in the first two or five years of claim. Combinations of extended elimination period and YRT would provide a combination of immediate risk sharing for high indemnities along with a level of long-term protection.

Reinsurance can also stabilize earnings by its participation in the client company's acquisition expense strain. In the case of extended elimination period or YRT, there is not really much relief in the acquisition strain; but in the coinsurance arrangement, the reinsurer would be responsible for the policy reserves on the amount that it reinsures and the allowance schedule, which is more heavily graded toward the first year, would help with the acquisition strain of commissions, underwriting, and other issue expenses.

A reinsurer may not be willing to assist in acquisition strain in some situations. If a particular client company increases its sales dramatically because it is severely underpriced in an area of experience concern, such as the 30-day elimination period business, it would essentially be asking the reinsurer to participate in both the acquisition expense strain and the poor experience. That may not be desirable for the reinsurer. Both companies need to agree on the degree and nature of market penetration to arrive at a mutually agreeable sharing of acquisition expense strain.

There is some opportunity for a reinsurer to get involved in smoothing out the investment risk for a client company, whether that be through a surplus reinsurance arrangement or whether that be with traditional reinsurance. In a YRT arrangement, the entire policy reserve is retained by the client company, so it is allowed the freedom and ability to do its own investing. If a company is not comfortable with its own investing, the coinsurance arrangement would allow the reinsurer to take some of the investment risk, since the policy reserves on the reinsured portion are held by the reinsurer.

Probably the primary reason why most companies reinsure disability income is to utilize the reinsurer's expertise. The lowest cost alternative might not be the best alternative for a company looking for reinsurance. Specialized expertise is essential in disability income, and using the experts in the field is very valuable. The reinsurance expert helps the client's bottom line as well as his own company's.

One area of expertise is underwriting. In many cases, the reinsurer's underwriters may be used just to confirm a decision that's made by a client company. It may be to confirm a decision on a case that the client really didn't want to take, or it may be to confirm that the case looks okay. Of course, there is facultative review for all of the cases that exceed the facultative limit, but in many instances a client company may request a reinsurer's opinion on cases that do not exceed the facultative limit.

The reinsurer can help the client company design the underwriting rules, underwriting classifications, and the application form.

This assistance may take many forms. Many times, the client company has ideas of what it wants to do and will ask for the reinsurer's comments on drafts of its underwriting rules, its underwriting classification guidelines, or its application. The reinsurer then would distribute the information to each of the different disciplines in its company -- to actuarial, to claims, etc. -- to gather comments and to pass those comments back to the client company. A reinsurer may provide a client with information on underwriting rules in the industry, either for industry leaders in disability income or for industry leaders plus some collection of companies that are similar in size and market to the company at hand.

Another area of underwriting assistance that has been increasing significantly in importance is in medical and financial expertise. Reinsurers' medical experts are providing more and more advice on mental nervous type disorders than ever before. On the financial side, the reinsurer may have specialized CPAs who are familiar with disability income policies, who know how income would be defined at time of claim, and who can evaluate different kinds of business entities that may be involved in disability income coverage.

The reinsurer may offer training sessions on these topics. Paul Revere has held several financial training sessions in which our in-house CPA has gone out to client companies and given training sessions to all of the people interested, particularly underwriting, legal, and claims, but also actuarial personnel, since the actuaries should also be familiar with the financial aspects of disability income.

The claim area is a very important area where the reinsurer can provide expertise. The reinsurer can provide advice on techniques and evaluation of claims. Again, in many instances, the client's claim department may have a process and a procedure that it is recommending to follow based on its evaluation of the claim and the client may be asking for confirmation of its opinion. In other instances the client may be asking for more in-depth evaluation. It may ask for some review of the forms used for evaluating claims. The reinsurer may have suggestions on the claims forms, on completion of the documentation of the claim, on how to document duties, on how to evaluate income, etc.

An important area for reinsurance consulting in the claim area is in medical consultation and, again, especially psychiatric consultation. The reinsurer's physician on staff or the psychiatrist on staff may be asked to contact the client company's physician or even the claimant's physician to discuss one-on-one what's going on with the case and evaluate the prognosis for continuation of claim. Equally important in the claim area is financial consultation. It is important to have the evaluation of a CPA who is familiar with disability income benefits and contract definitions, particularly for residual claims.

Rehabilitation assistance may be available through a reinsurer, either through specific services or through an analysis of the appropriateness of rehabilitation for a case. Also, in some instances the field claim representatives of the reinsurer might be available to provide investigative service for a client company. These field claim representatives are familiar with various areas of the country and can contact the physician, the employer, the claimant, and the claimant's accountants or lawyers, as needed, to evaluate the particular claim at hand and to give the client company advice on alternatives to take on the particular claim. This service works out best if the field claim representatives have some authority to make some level of claim settlements on the spot for the client company. Having settlement authority is not always necessary, but it does give more leverage.

The reinsurance company can be asked to give legal advice. In many situations, a client company's legal staff may not have experience with a type of disability income claim, since the client company may not have many disability income claims that go to litigation. The legal department of the reinsurer can provide information on what types of results it has had in litigating those types of claims.

For claim settlements, the reinsurer can get involved in evaluating a case for the appropriateness of a claim settlement and also on an appropriate dollar amount of the claim settlement. What is a true claim annuity for the particular claimant at hand? Is there excess or reduced morbidity expected? What is the excess mortality, if any? The reinsurer can help determine a break-even point for a claim settlement amount for the company's financials over the entire period that the claim would be expected to continue. The reinsurance company can also help identify cases in which there may be suspected fraud and help establish a strategy for handling such claims. Each client company, then, takes the information learned from claim situations back to underwriting and to the marketing areas so the business can be properly managed in all areas.

In the actuarial area, the reinsurer provides advice on trends in the industry. That information may be gathered from different industry tables, company tables, reinsurance client tables, etc. These various sources are used to identify trends in the industry as a whole and also for the client company's experience.

The reinsurer may track the client company's mix of business in relation to experience trends, to identify where the company should use caution. For example, as Bob mentioned, there are some concerns in California. The reinsurer may track the mix of the client's reinsurance business in California, for both new and inforce business, to make sure the client company is aware of its own penetration in this market. As another example, the industry has seen increasing morbidity in the 30-day elimination period experience. The reinsurance company can keep the client informed of such an experience trend and on responses that various companies have considered or implemented in relation to the experience trend. The response of each company may be different, depending on the company's policy benefits, market emphasis, or distribution methods.

Of course, in evaluating a client's reinsurance experience, the reinsurer's actuary must take credibility into account. Two or three similar claims among a small number of claims could be an indication of a problem, or simply sparse data.

The reinsurance actuary can evaluate pricing assumptions, including persistency, claim costs, select or antiselect factors, and expenses and evaluate how the client's assumptions compare with others in the industry. Another area of actuarial assistance is in reserve evaluation, primarily in claim reserve evaluation, but also in policy reserves and the incurred but not reported claim reserves as well. The reinsurer and client must make sure that reserves are adequate to provide for the eventualities promised.

In product, the first thing a reinsurer must do is evaluate the market that the client is trying to penetrate and the appropriateness of the client's product for that market. All of the reinsurer's disciplines get involved in this evaluation, including marketing, actuarial, underwriting, claims, and systems. A reinsurance review of a product design prior to implementation allows the client company to make modifications as it sees fit. If there are benefits about which the reinsurance company is concerned, experience tracking those benefits can be set up to evaluate how the benefit may be influencing experience. The reinsurer can give competitive information on product variations in the industry and how a client company's product compares. Is there anything in that product

that gives a competitive advantage or disadvantage or a profitability advantage or disadvantage?

In the area of management, the reinsurer has been called upon to discuss the role of disability income in the client company. Is disability income accomplishing the company objectives for that line? If not, then what are the alternatives? The true potential for disability income in the company must be candidly assessed, to allow the company to make the most appropriate choice for its future. Most often, the product champion for disability income is found in the management area. In addition to profit responsibility, a primary function of the product champion is to make sure that the communication between all of the different disciplines is occurring, and that the direction that they're taking as a group will produce the results they desire.

Reinsurance can be very valuable in helping a company manage its bottom line for disability income. Reinsurance provides risk sharing, earning stability, and specialized expertise to control experience for a very complex line of business.

MR. KIDWELL: We all know, from sad experience, that a business ignored degenerates rapidly. When control is eased, selfish interests tend to dominate, and financial balance is tilted. Good management reports are essential to maintaining control, and control is essential in managing the bottom line.

Managements at all levels must be given the tools necessary to carry out their particular responsibilities. Management reports should be designed for specific, practical purposes. A report for a particular manager should focus on items under that manager's control, and upon which that manager can take action. For example, claims and underwriting management people have very fine control. They need detailed reports for time service and expense control, as well as morbidity. Senior management has much broader control, and as a practical matter needs, and can use, only reports giving the broad overview.

Statutory and GAAP statements provide broad information on how the business is doing in general, and statutory indicates the ability of a company to meet its future obligations, but neither report provides sufficient detail for hands-on managing. Both types of statements' audience is senior management, the general public and the regulatory authorities.

Both statutory and GAAP statements tend to be aggressively managed, for good business reasons, and it is sometimes difficult to evaluate their credibility as a measure of a single year's performance.

Credibility has been particularly elusive in disability income reporting, largely due to numerous concurrent changes in product design, and valuation standards. In recent years, the changing of reserve methods, increasing of valuation interest rates, introduction of new morbidity standards, and the delayed impact of the high cost of new benefits, disguised the very serious downtrend of industry profits. With more consistent and more timely reporting, the fight to regain control and to set proper prices would have begun much sooner.

GAAP accounting is based upon assumed most likely assumptions with realistic margins. It has been handicapped by having only the pricing factors for guidance, and the pricing morbidity factors are proving to be optimistic. Much of the profit imputed from morbidity margins will not appear. Our main hope for a bail out is in the much-better-than-expected investment experience.

Loss ratios have traditionally been the most popular of management reports for disability income. They are easy to obtain, easy to explain, and timely, and as long as they are defined consistently from year to year, they provide a fairly good indication of the level of experience and the direction of trends. Loss ratios are frequently used as guides in empirically developing disability income pricing tables.

Cash loss ratios of claims paid to premiums collected is not a significant report for most disability income management. The level premium approach and the long-term nature of the benefit involves a major mismatch in the timing of premium payments with the corresponding claim payments. A cash loss ratio's use for disability income is essentially limited to its role in cash-flow analysis.

Nor are incurred loss ratios the full answer. Like annual reports, they, too, are managed -- sometimes directly, by reserving techniques, and sometimes inadvertently, by timing of the mail and by company handling priorities. When claim volumes are high or personnel is scarce, we think first of service to the claimant, getting him a check. Record keeping temporarily suffers. As a result of these arbitrary priorities and the small number of claims, statistics tend to bounce around.

Incurred loss ratios attempt to measure the portion of the premium being used for policyholder benefits. Incurred loss ratios, generally defined as, "losses incurred divided by premium earned," take several forms, depending upon whether the change in active life reserves are:

a. added to the claims incurred as a benefit;
b. deducted from the premiums as unearned; or
c. treated separately; and whether
d. the tabular interest is deducted from the benefits.

Each combination has meaning to an analyst as long as the definition is clear and is treated consistently from year to year. Each will give a rough indication of the morbidity trend, and a crude estimate of its effect on profitability.

This flexibility is consistent with the intent of Schedule H in statutory statements. Frequently, Schedule H numbers must be modified to include the results of downstream companies or sister companies, or to adjust for reinsurance or for the effects of surplus relief treaties, to obtain a more realistic underlying experience of the line.

Statutory Schedule O is intended to test claim reserve adequacy. Schedule O numbers need to be adjusted for tabular interest and should be extended to at least five years, to obtain a more realistic reserve run-off exhibit.

In recent years, tabular interest has become increasingly significant because of greater proportions of longer benefit periods and rising valuation interest rates. The combination of (a) and (d) may be referred to as the "net benefit," and its ratio to the premium earned can be called the "net benefit ratio." The net benefit ratio gives a more logical representation of policyholder benefits to premiums than does (a) or (c) alone. Net benefit ratios are 5-10% lower than other "incurred loss ratios."

Incurred loss ratios for finer breakouts of business, such as by policy form, class, age, or sex are often expressed as, "cash claims plus the change in claim reserve," divided by "earned premiums." Earned premiums in this instance are generally the gross premium for the period of exposure. This method eliminates the need for distributing the change in the incurred but not reported reserve, by leaving the study period open until essentially all reporting has occurred. Since all lapses are also known, the data are essentially complete.

Management is familiar with this type of loss ratio, and has formed a mind-set of a level of comfort with this expression. Comfort ratios of regular fully underwritten noncancellable policies are 45-50%. When the policy reserve increases are included, comfortable numbers are 55-60%.

Many companies manage from detailed profiles of the characteristics and experience of their disability income business. These reports include policy count, base amount of monthly indemnity, premium earned, loss ratio, claims incurred, and sometimes the policy reserve.

Such reports may be by agent, agency, geographic location, age group, sex, duration, policy form (with and without certain special features or riders attached). They may be by issue year, occupation class, elimination period, benefit period, level of underwriting, underwriting decision, or occupation code.

These voluminous reports are the most important fine-tuning statistical tools management has. Profiles identify areas that warrant further review, and they may be the primary support for changes, up or down, in your occupation rating schedule.

Quite obviously, many of the cells are so small that any one year's loss ratio is useful only as an indicator that further review may be advisable. A very bad loss ratio for a particular cell, (i.e., an agent), is probably due to normal statistical fluctuations, but it certainly should be reviewed further, just to be sure.

Crude lapse rates are frequently an added feature in a set of profiles. They provide for adequate monitoring while you wait for the next detailed persistency study.

The most meaningful reports for monitoring morbidity are the actual/expected (A/E) ratios of the rates of incidence of disability and the A/E ratios of the rates of termination from disablement. In combination, they provide crude A/E claim cost indexes. Such studies provide basic information at the lowest level of pricing. They enable monitoring at the earliest possible stages after issue, becoming increasingly significant as data build in volume and more cells become credible.

A/E ratio bases by form, class, age, sex, elimination period, benefit period, accident/sickness, and duration can be developed to your pricing assumptions or to your valuation table. A standard base is needed because you are primarily interested in the deviation from this standard. The base A/E factors can best be developed from your own internal block of recent issues. You are looking for a reasonable point of reference, as a starting point.

Changes in an A/E ratio from year to year will prompt fine-tuning actions. For example, if you observe that the A/E incidence ratio is rising materially, talk with the claims people. They will give you valuable clues as to whether this increase is being caused by a seasonal surge in minor respiratory ailments, (a statistical variation), or if there is reason to suspect poor field underwriting or inadequate internal underwriting? Review a few claims to see if there are specific agent, underwriter, or claims handling problems. If there is no obvious clue, the claims may be occurring "normally." If this is the case, your contract may be too liberal, or perhaps your pricing assumptions are inadequate.

It is always possible, of course, that you allowed for some deviations from the standard in setting your original prices. For example, policies with cumulative elimination periods are expected to have a higher incidence of claim than policies that require an uninterrupted period of disablement to satisfy the elimination period. These A/E ratios will help you evaluate the adequacy of the additional amount you allowed for in pricing.

Sudden increases in A/E termination ratios may be only the result of a seasonally higher volume of mild claims, consistent with higher A/E incidence ratios. Deteriorating A/E termination ratios might prompt questions about your claim handling technique, possible weaknesses in product design, antiselection from chronic disease, overinsurance, or possible economic influences.

Here, as before, your most useful and readily available analytical asset is talking with the actual claim handlers, and reviewing a few claims personally. Claim personnel can frequently tell you about emerging problems long before you see them in the data.

Here, too, you can test your pricing judgment of the added extra you assumed for any unique benefit features. For example, you probably assumed that the cost-of-living adjustment (COLA) benefit would add some extra amount to the claim cost of the basic policy, and you built that into the price of the cost-of-living feature.

Thus, for policies with the COLA feature, you may have expected a slowing of recovery rates during the two months preceding and two months following the scheduled COLA increase. Comparing the A/E ratios at these points for policies with and policies without the cost-of-living benefit will give you an evaluation of your good judgment. Similar approaches would be used to test the assumed extra morbidity for policies providing residual benefits, premium refunds, endowments, or other special features.

A/E trends that appear to be favorable may not be considered favorable if they result from excessively tight underwriting or overly aggressive claims handling. In the one case, you may have lost valuable sales and irritated your sales force, while in the other you may be subjecting your company to legal actions. A/E ratios should be run for as many

cells as is practical, leading of course, through summary steps, to an aggregate overall ratio. In your analysis, you must evaluate the credibility of each level. The totals ratio should be consistent with your financial forecast and your statement results.

Such A/E studies sound formidable, but the volume of individual disability income policies is very small, and the time consumed for processing is easily practical for quarterly reports.

The unit of exposure can be policy count or amount of indemnity. Count is more reliable and practical to work with since the amounts of benefit, whether base amounts or paid amounts, are often variable.

Frequent marketing reports are needed to tell management how well a product is being received by the public, or at least by the agency force. These reports are particularly essential for a new product or a repricing action. You may be deliberately trying to promote a particular product or to soft peddle another, and you need to know if you are succeeding. Sales reports by policy form will provide an answer.

Excessive sales of a particular policy form may be an indication that you have genius at work in your product development and marketing team, or it might indicate serious trouble in product design or price. You need to determine which it is, as early as possible. If it is the former, reinforce your good advantage. If it is the latter, you need to take a quick remedial action.

Special persistency studies for pricing and valuation purposes are usually performed annually. Their reports provide the necessary contingencies for expense amortization, as well. The amount of detail should be determined by your pricing needs. In contrast to this, lapse rates in the profiles or marketing reports can serve well with more practical handling. There, the simple probability of a policy continuing in force to successive anniversaries is usually adequate.

Annual statements, loss ratios, A/E studies, persistency studies, profiles, and marketing reports are the primary reports used to manage morbidity levels for pricing and valuation. There are also, of course, the normal myriad of indispensable periodic reports used for regular accounting purposes, expense control, and time service.

Good management requires much more than good reporting. It requires backup commitment at the very highest level, with fully dedicated senior disability income management. Management must be available to act when action is needed. Your pricing action should be a company plan. Each member of the pricing team has made a commitment, and should be held fully accountable for that commitment.

As disability income managers, you cannot wait for things to happen. You must not dally for data. You must use your own initiative and your native resources. Talk to claims people, the underwriters, and marketing personnel. They can usually tell you whether something's going wrong long before you see it in the data. Furthermore, they can often tell you how to fix it. Reviewing your bottom line will then be a most pleasant experience.