RECORD OF SOCIETY OF ACTUARIES
1994 VOL. 20 NO. 3A

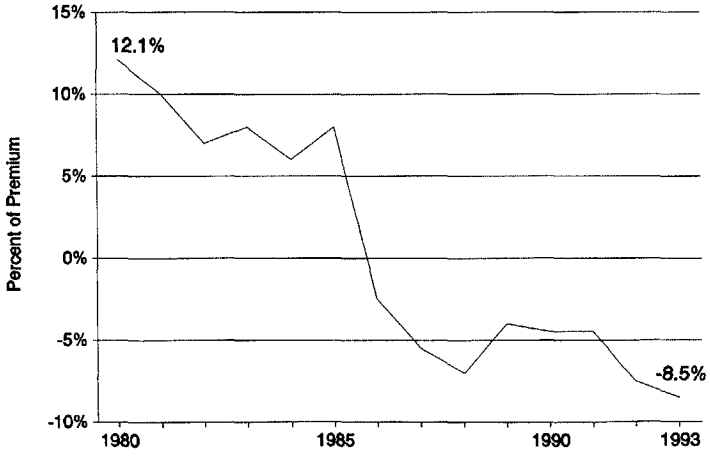
HOW DO YOU MAKE A PROFIT IN INDIVIDUAL DISABILITY INCOME (DI)?

Moderator: DAVID E. SCARLETT
Panelists: DAVID W. LIBBEY
HOWELL M. PALMER III
DAVID W. SIMBRO
Recorder: DAVID E. SCARLETT

Panelists will discuss actions they have taken (or that need to be taken) to produce a profitable DI product line. Comparisons will be made to historical practices and results.

MR. DAVID E. SCARLETT: Chart 1 shows statutory profit (as a percentage of premium) of the nine largest DI writers in our country. The profits before dividends started at a healthy 12.1% in 1980, but it's been steadily downhill ever since, reaching the lowest point of negative 8.5% of premium in 1993. The 1993 profits after dividends was negative 9.2%.

CHART 1
PROFIT



Our panelists are going to show us the way out of this morass and answer the question, "How do you make a profit in individual DI?" Dave Libbey is going to lead off. Dave is from Paul Revere, which is a large stock company. Dave Simbro is from Northwestern Mutual, which is a large mutual company. And Howell Palmer is from Berkshire Life, which is a smaller mutual company. I think we have a pretty diverse group on the panel up here: large stock, large mutual, and smaller mutual.

I'd now like to introduce Dave Libbey. Dave is vice president and actuary at Paul Revere Life Insurance Company. He's in charge of risk management, valuation, and forecasting results for the individual DI line of business.

MR. DAVID W. LIBBEY: I'd like to spend some time discussing two major, or key strategies that I believe are very important to managing DI to a profit. And then I'd like to talk about some recent experience trends that we've been watching at Paul Revere.

How should we manage the business? There are two basic strategies: practice the fundamentals, and make decisions well. I think if we do those two things, a lot of other good things begin to happen.

First of all, understand your block. This sounds like it's a very innocuous sort of a thing, but what I'm driving at is this: acquisition is a place where business starts. I believe that it's important that we understand the economics of the acquisition process—where we're spending money, what it costs to put business on the books, and what we're getting for it.

Second, we need to know the demographics of the business that we're selling: what markets we're selling in, who's buying our business, who's selling our business. Perhaps more important than anything else related to that point, is to watch that kind of information regularly year in and year out, more frequently if possible. Understanding the demographics and what's going on in them is a significant contributor to being able to manage DI to a profit.

In this broad category of understanding your block are the two key things that drive earnings once the business is on the books: policy persistency and claims. Policy persistency is one of those things where you need to have a macrolevel indicator so that it's easy to communicate to senior management what's going on. But it's critical to be watching your persistency in all the cells that you believe are important to you. And again, as with the demographics of your sales, it's very useful to watch that on a regular basis.

Let me turn to claims. This begins to sound a little bit like a repetitive pattern, and I hope it does. Consider demographics. Where are your new claims coming from? Who's going on claim? What are the causes of claim? What's your existing claim block look like? Watching that information, and understanding the trends, is a key part of understanding your block of business.

Finally, within this category of understanding your block, is being willing to take action when it's necessary. It sounds like a very simple statement. I'm going to come back to that later.

Another fundamental, I believe, is selling good business. That starts with knowing where your profitability is and where it isn't. Understand the cells that you're selling today that are generating the kind of profit you want. You need to have some macromeasures certainly, again, as communicating with senior management is important. But in order to sell good business, you need to understand that certain mixes of issue age, elimination period, benefit period, and so forth, are where higher profits come from.

Tied to that, of course, is your pricing structure. Knowing that your pricing structure accomplishes what you want it to is a key piece of the action. It's critical to know

where the subsidies are in your pricing structure. And it's important to be sure that your pricing structure is tied to your portfolio, marketing thrust, underwriting process, and claim practices.

All this leads me to agent behavior. Who is selling your business? I mentioned that earlier under the topic of sales demographics. But are you paying your producers to sell the business you want them to sell? And are they, in fact, doing it? If you're not and if you're not rewarding them for doing what you want them to do, then you're very likely to find yourself selling the business that's not so profitable. A final point: be ready to act when you see things you don't like, or when you see opportunities.

Underwrite for profit. It seems like a simple thought. But so often it gets a little bit lost somewhere in the process. Let me start here by saying that success is spelled field plus home office. There is no way that a home office underwriting department can underwrite for profit without the clear and thorough involvement of your field force whatever your distribution mechanism may be. The underwriting process must have both a field and a home office focus. It has to involve both. Both need to understand it, have a clear view of what you're trying to accomplish with your underwriting process, and be committed to it.

That comes back to a distribution point. We need to know our distribution system and know it well: what it's doing, why it's doing it, how it's responding to the company's underwriting philosophy, if you will. The underwriting guidelines are a key part of the process. I don't think it's possible to mandate underwriting from the home office. I do think it's possible to develop a good underwriting process when you're thoroughly involved with your distribution system.

It is crucial today to be willing to invest in the underwriting process. I think we all know that underwriting is becoming a more complex, more expensive, more difficult task. That generates additional cost strain on the business that we're selling. Being willing to invest in people, in systems, and in technology to constrain the cost of underwriting while getting what we need out of the process is a key element here. Periodic reviews of your underwriting rules and requirements should include a fundamental step, an assessment of your underwriting philosophy, the culture of the company in which you're selling and trying to manage a disability business.

And what your total portfolio that you're selling looks like is another key factor in underwriting for profit. That's both a very conceptual, almost metaphysical sort of an idea in combination with a very practical down to earth process that involves staying in close touch with what your underwriting guidelines are. And finally, you need to be ready to act.

You must also manage claims proactively. That begins with a clear philosophy for what your claim management process is supposed to accomplish. It means saying something like, "We want to pay the legitimate claims promptly and fairly; we want to be able to weed out the claims that don't deserve to be paid; and we want to provide that in the context of solid service to our insured population." From that comes all the rest.

But number one within this broad context of having a clear claim philosophy is to know exactly where you are. Track your experience. Follow the demographics of your claims. Identify where you think you have problem areas and where you think things are working well. Getting outside the nine dots, so to speak, is really dependent on finding new ways, better ways to handle your claims. It's really dependent on knowing what's working well and what's not.

You must also make sure that your reserving practices are well-tuned to your block of business. There's nothing more disheartening, I think, than watching your financial results and coming to the realization that maybe they're not as good as they look because valuation assumptions, basis, and so on are not properly tuned to claim practices.

Be ready to invest in the claim process. Invest primarily in the resources that are needed to get the job done. Front-line troops are the claim examiners. It's necessary to have a very solid idea of how many open claims at a time one good claim examiner can handle, and know when you're straying from that.

Behind the front-line troops are the support units. By that I mean rehabilitation units, psychiatric management teams, certified public accountants (CPAs), physicians, investigative units, both home office and the field, and several others that we haven't thought of yet. But I think you get the picture. The point is those resources are keys to helping those front-line troops do their job. And finally, be ready to take action.

One of the key points that can be made about any business, and it's certainly true of the DI business, is that you need to establish clearly what the role of the disability business is within your company. And that means that you have arrived at the viewpoint that the DI business has to be managed carefully in order to achieve that role.

A key component of managing it well is having a solid decision-making process. It starts with some ideas like having a balanced, inclusive process—one that involves every discipline that's important to the line of business. One, we hope, that brings to it a mixture of resources, and by that I mean people who have the ability to bring solid experience and a good sense of the business to the table, as well as data that you can gather from your business and from talking with folks around the industry. But data are not enough.

Staying in touch is probably the key point. Talk often. A dozen five minute conversations, one hour of time, sprinkled on a regular basis with your key people is much more effective at managing this business than spending an hour in a meeting to deal with a crisis among people who aren't accustomed to coming together to deal with those types of issues. This approach provides and builds on a good instinctive capacity to manage the disability business.

Consider delayed penalties and rewards. This is something I stole from someone who wrote it a long time ago, but the point is that the decisions that we make today will affect the rewards we reap tomorrow, or the problems we face tomorrow. Making those decisions today is frequently a task that needs to be done in a context where you simply don't have clear solid definitive data. Either you don't have enough

business in force to generate credible data, or even if you have lots of business in force, you may not be able to see what you need to see in order to make a clear-cut call at any point along the way. Being ready to make decisions is often something that depends very much on experience and feel for the business.

Probably the toughest part of being ready to make decisions is the concept of trends versus fluctuations. The goal, of course, is to see changes in trends and respond well to them, and to not respond to things that are mere fluctuations. But how do you tell the difference? I think it's fair to say it's one of the toughest parts of managing the disability business. There's no clear-cut easy way. But there are a couple of things that we can do that will make it easier.

First, put the information that you're looking at in the historical context of your own business. That goes all the way back to focusing on the trends or looking at information gathered over a significant period.

Second, have some feel, given the size of your block business, of how large a statistical fluctuation might be. When is something clearly beyond that realm? That gives you a ballpark to operate within. Understanding your block very well helps a lot here. And probably the key part of that is understanding what your profit drivers are. What's making your business profitable? What's getting in the way of that? When you know those things, you feel a lot better about trying to make a call between fluctuation and change in trend.

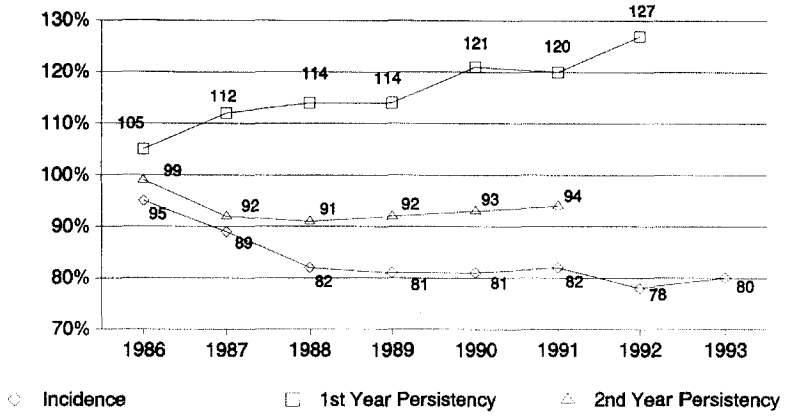
Having said those things, I'll still argue that it's just not easy. It takes a lot of thought and it takes a lot of consideration from the viewpoints of different disciplines involved in managing the disability business.

Finally, follow through. Get buy-in for the recommendations you want enacted. Make sure they happen. Check on the results, and if you don't like the answers, take action again. I think a key point here is the perspective that we, as actuaries, can bring to this decision-making process.

We are uniquely qualified to balance all of the different viewpoints that can impact the disability business. We're in a good position to bring a healthy sense of skepticism to the process of managing the business. We're also able to help others see the big picture. There are times when that gets lost along the way. And times when we, as actuaries, take a narrow actuarial view when, in fact, what's more necessary is the broad-based disability management view. Understanding the interplay of underwriting, sales, claims, and so on can be a big benefit.

I'd like to move on to talk about some experience information. I'd like to first talk about some claim trends, and then persistency trends. Chart 2 shows actual to expected information for our U.S. business. There are three lines on the graph. The bottom line is our actual to expected incidence experience. The top line is our first year of claim persistency experience. And the middle line represents our second year of claim persistency data.

CHART 2
CLAIMS ACTUAL TO EXPECTED TRENDS
U.S. BUSINESS



Final Year Estimated

The reason those all end at different points is that each is tied to a disability year. So, for example, we're able to see actual to expected incidence experience from 1993, but we're really not in a position to measure first-year claim persistency for those 1993 claims. The long-term trends, and these go back quite a ways, of improving incidence and worsening claim recovery are continuing. I don't see any major changes in those two trends.

If we look at incidence, the bottom line on the graph, it looks pretty good. We see a dip down in 1992 and a little bit of a bounce back in 1993. Actual to expected incidence, on the expected basis we're using, has dropped from 95% in 1986 down to 80% in 1993. That's good news.

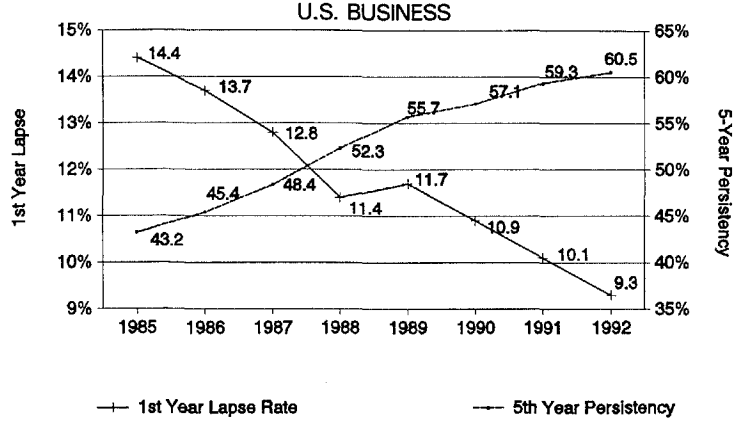
The top line isn't good news. The top line shows continuing deterioration in claim persistency. And what that's saying is that claims are staying open longer, or recovery is deteriorating, however you want to say it. What I don't like is that bounce up to 127% of expected for 1992 disabilities. Is it a change in trend or a fluctuation? That's a good question. We think it's a little bit of both.

The second year of claim persistency data shows a very steady gradual deterioration in the second year of claim. That's not good news either. It would be nice to see that stabilizing and flattening out. So the overall conclusion here is that the trends are certainly continuing and that it's appropriate to focus some additional attention on how we manage our claims to improve our recovery experience.

Now I'll talk about policy persistency for a moment (Chart 3). The left hand scale and the line dropping from left to right shows our first-year lapse rate experience. The right hand scale and the line rising from left to right shows our cumulative fifth-year policy persistency rate. That's the first five years combined together. And you can

see that both of those lines are demonstrating very good news. Persistency has been steadily and dramatically improving.

CHART 3
POLICY PERSISTENCY TRENDS
U.S. BUSINESS



I have just a couple of quick comments. The first-year lapse rate has dropped by 35% from where it started during this period, from 14.4% down to a little over 9%. The five-year persistency rate has improved by 40%, from around 43% to just over 60%.

Looking at the last three years, 1990, 1991 and 1992, the first-year lapse rate has dropped roughly 7.5% a year. The five-year persistency rate has improved by about 2.8% a year. And the renewal-year persistency in that five-year rate, years two, three, four and five, has improved by about 2% a year. So we're seeing both first-year and renewal-year improvements, but the more dramatic improvement is in the first policy year. Overall, we don't see anything unusual here. No issues emerged. I think our only question is how good can it get before it stops getting better.

So I think that it is, indeed, possible to manage the disability business to a profit. It's not a simple task. It's built around keeping track of a lot of information like this. I commend this type of analysis to you.

MR. SCARLETT: Let me now introduce to you Dave Simbro. Dave has the title of actuary at Northwestern Mutual and is in charge of pricing and product development for individual DI and group long-term disability (LTD), and he's also responsible for managing long-term-care research at Northwestern Mutual.

MR. DAVID W. SIMBRO: There are two things I'd like to cover in my short discussion. First is to review why I think there has been a lack of profit due to morbidity increases. Second, I will discuss what our company has done to improve profits and the opportunities that I see out there for all companies to consider for improving profits.

In a nutshell, I think a lot of evidence indicates that the main cause of the morbidity experience decline has been activity we have undertaken. There is some evidence that societal changes have occurred. There is probably more of an entitlement attitude. Also, some losses may be due to economic conditions. But I think, far and away, the evidence would indicate that the biggest factor that led to experience declines, in particular, morbidity, has been things that we did.

I'll point to a couple of examples of other lines of business that insure disability, which have not seen nearly the deterioration in morbidity experience that we've seen in individual DI.

I would suggest to you that it may be very beneficial if you have an opportunity to study your own company's waiver experience on the life insurance side. We've recently taken a look at that again and have found that, over roughly the last ten years at Northwestern, our waiver experience, as far as claim cost, has been very stable. This certainly has not been true for DI, and yet both of those are insuring against becoming disabled. I think there's something inherent in what we've done on DI that's caused the problems.

Also, if you look at the group LTD industry, while it has had some decline in profit, it hasn't been of the magnitude we've seen on individual. And I think part of what's happened on the LTD side, in particular, is that premiums have become quite a bit lower, and that may have caused part of the profit decline. I don't think LTD has seen the same morbidity increases that we've experienced on the individual side.

On the LTD side, every year John Antlift conducts an annual survey of 22 or 23 insurance carriers. In the period of the early 1980s the 14.0% profit percentage aftertax is fairly consistent over about a three- or four-year period. It drops in the later 1980s to around 8 or 9%. It took a very recent drop in 1993 down to 3%, and while that's not a real positive sign for the LTD industry, it certainly is not of the magnitude we've seen on the individual side. And again, I think part of that is due to premium declines, in particular, on the LTD side.

So my basic assertion is that we've done this to ourselves. What are some of those items we've done? I think they can be generalized into two broad categories. There's a category of soft issues, which I'm not going to dwell on much. I don't think they have been the predominant cause, but I think they're a piece of it. These are things such as field training, underwriting rules, and claim management. These items tend to be harder to quantify.

The things I'm going to discuss a little bit more, as far as what we've done, are premium changes, contract changes, and coverage changes.

As far as those "hard" issues, if you just think about the loss ratio in terms of benefits paid divided by premiums collected, think about the number of major things we did in the 1980s making it easier to qualify for benefits. We had all kinds of changes to the definition of disability. We also made it financially easier to be on claim. Changes to the coverage levels led to increases in claims. In the early to mid-1980s premiums were also cut. All of this led to a result which was not surprising. Experience results have declined.

If you look at the period of the mid-1980s, premiums declined, and it wasn't until the very late 1980s and the early 1990s that companies started reversing that trend, and you started seeing some premium increases.

On top of that, companies, if they weren't already, went to a sex-neutral pricing basis. This may have been in part what has caused the change in a lot of companies' distribution of business by sex. Females have historically shown a very different pattern of morbidity cost. With females becoming a higher percentage of the in force, and with sex-neutral premiums, this created some pricing inequities and financial problems for companies.

On top of that, contracts were changed. One of the big items was companies covering normal pregnancy. On top of that, there were all kinds of changes to the definition of disability. Everything from companies not requiring someone to work to be partially disabled, offering partial benefits, and transition benefits. All of these were liberalizations in the earnings that could be used to serve as the basis for residual benefits. All of these changes may fit a need, but the bottom line is they made it easier to qualify for benefits.

A final item, which I personally feel is the big ticket item, were changes in the coverage levels. I'm not referring to situations where there may have been overinsurance, but the bottom line is just situations, in a lot of different ways, where we increased the amount of coverage provided. And there's a lot of evidence and literature that shows that, when coverage goes up, claims go up. In fact, it's pretty much a one-to-one correlation; when coverage goes up 1%, rates of claims go up 1%.

This phenomenon is studied on the LTD side and is published in Society of Actuaries' studies. This correlation has also been discussed in workers' compensation studies. Finally, there was a Menninger Foundation report a number of years ago that showed a longer period of claim for higher coverage levels.

The bottom line is that there is a direct link between more coverage and more claims. Another big change in the 1980s was no longer requiring those insured, to purchase a social security substitution policy. All companies provided more coverage for benefits that were taxable. Maximum benefits were increased. Companies provided higher replacement ratios when a portion of the coverage was LTD. Finally, the concept of offering indexed benefits led to more coverage.

As a result of these changes, most companies have experienced a decline in profits. A number of companies have reacted to this decline. Our company reacted to this decline by shifting our focus to the more specific things we did, the soft items. For instance, monitoring our field's claim results. If these results deviate dramatically from the norm, the agent will be unable to write future DI business for us. On top of that, we have increasingly focused attention on claim management opportunities.

But what I really want to focus on are some of the hard items that we've changed. The key to these hard items is having a detailed study system available to pin down the sources of the problems. We spent a good deal of resources in the very late 1980s and the early 1990s putting in place huge improvements to our study

capabilities. Our company has found it very beneficial to be able to identify the particular problem areas that has effectively led to three rounds of rate increases.

We recently instituted our most recent policy form in March 1994 that, in general, had higher rates. However, the rate changes vary dramatically by various cells and that gets at the issue of improved rate equity. We've taken this opportunity to go back to sex-distinct pricing. We added an area rating structure and dramatically changed our occupational classification based upon the study systems. We are also now restricting what is covered under normal pregnancy and only cover that after 90 days of claim.

We also added the requirement that you have to work to be partially disabled. This isn't a severe requirement, if you look on the flip side, it seems to be somewhat silly for someone to be able to collect a benefit when he or she has the capacity to work on a part-time basis. In the past we paid a 100% benefit if someone had a partial disability. As a result, we experienced a dramatic increase in the volume of claims in that scenario.

The final item we have changed is our coverage levels. We have reduced our issue limits for those who don't voluntarily provide us with a tax return. If they voluntarily provide one, we offer a slightly higher coverage.

All said and done, we do not feel we have made every change possible for improving our bottom-line results. Over the last few years, we have had statutory gains. In 1993 alone, we had a $30 million pretax statutory gain. However, that $30 million gain, looked at purely from economic terms, does not support the surplus growth required for the line at a higher level.

Looking ahead, we feel there are some opportunities to consider. One is with coverage levels. There were a lot of changes in the 1980s that I already alluded to. I don't think we, as a company, have made that many changes, and I don't think the industry has changed back to simply where it had been before. I think there's a real opportunity here with coverage levels to impact results if individual companies so choose.

Our own estimates are that changes to coverage levels may be a cause of over 50% of the claims runup. There's an article that Bob Meilander and I wrote in the *Disability Newsletter* where we discussed this issue.

One reason for changing coverage levels is the idea of a taxable benefits rider. The idea is that, if you provide higher coverage to someone because the benefit is to be taxable, you should make sure that you're actually paying the extra benefit only if the benefit itself actually turns out to be taxable. A much smaller percentage of the benefits are paid to someone in a taxable scenario.

In addition, the benefit level could change when social security provides benefits. I think most of us are fairly familiar with this. It's quite enlightening if you take a look at, say, someone with an income level of $40–60,000. If you look at the replacement ratio that occurs if the individual collects not only the benefit from your company, but also a social security award, you can see replacement rating well over 100%.

On top of that, there certainly would be opportunities for lowering the maximum amount of coverage. The bottom line is that the maximum coverage levels have gone up. Some companies have reverted recently to a $15,000 level, and that may be worth considering.

Another idea is to just lower the replacement ratios for all incomes. A final idea is eliminating the LTD "bonus" in the issue limits. Why should that be underwritten the same as any other piece of coverage?

Beyond issue limits, there are other opportunities. And again, I'm still focusing on those hard issues. Our company is doing a detailed review of the various costs of the features in our policies. I think you may find a few surprises when you look at what features you need from a marketing end, or from a needs perspective and the cost of those features. There may be a mismatch at times.

A second idea is basically to have a stronger link in the contracts between the loss that's incurred and the benefits paid.

The final idea, is purely my own personal opinion, and that deals with changing premium levels. We've gone through a number of rounds of rate increases. A lot of other companies have changed rates. They've gotten higher and higher. I have started to wonder whether or not the market will continue to pay higher and higher premiums. I think there's a real need for companies to seriously consider finding other ways to improve bottom-line results other than just changing premiums.

I think it can be somewhat enlightening if you compare premium levels for an individual noncancelable product to something that's offered on a small group LTD basis, or a ten lives group LTD basis. You can certainly see the potential for the market shifting more and more to the group route.

MR. SCARLETT: Those of you who read the *Disability Newsletter* know that we follow the 22 largest disability companies in reporting the financial experience of the DI industry. Out of those 22 companies, if you look back all the way to 1980, there's only one that has reported positive statutory earnings on individual DI every year of that period of time, and that's Berkshire Life Insurance Company.

What do they know that the rest of us don't know? Well, maybe we're about ready to find out. I'd like to introduce to you Howell Palmer. Howell has the title of senior vice president and actuary at Berkshire Life. His responsibilities are those of chief actuary and chief financial officer at Berkshire.

MR. HOWELL M. PALMER III: One of the things that I didn't realize until I was here is that we're supposed to be paying claims on these policies, which might explain the profit figures that Dave talked about.

I'd like to tell you a little bit about the company because I'm sure you're a lot more familiar with Paul Revere and Northwestern than with Berkshire Life, and I think it will tie in a little better with what we're able to do and some of the decisions that we've made along the way, which few companies have been willing to make.

Berkshire is a small- to a medium-sized mutual company. We operate nationally, although the vast majority of our business is on the eastern seaboard. We are a New York company, and about a third of our business is in New York. We operate through a general agency system. Within that system, about 50% of our DI business is done by our own career agents, and the balance is done by brokers through the general agent. And these are typically brokers that we've been doing business with for a long time. So there are relationships there that are longstanding.

We do about $3 million of new DI premium a year. We have about $27 million of annual DI premium, just to give you a frame of reference. It's obviously not a huge block of business by industry standards. And some have argued, and I'll come back to this a little later, that size is something that should prohibit a company from being successful in the DI business, and we are a counterexample to that.

As Dave has indicated, we've had statutory profits each year for the last fourteen years or so. Our morbidity ratios have averaged about 45% over that period. And those may or may not be the lowest in the industry, but they're certainly close. We really focus in three areas as the profits in the business ultimately are driven by the field, your underwriters, and the claim people. Those are the three key areas on a day-to-day basis in making this business work.

Now behind all of that, you have to be making good decisions, and I'll talk about that a little bit later. Our field force is operating in a very upscale market, as are a lot of the other companies. We have among the highest percentages of chartered life underwriters (CLUs) and chartered financial consultants (ChFCs) in the business as a percentage of our career agents. It's a very professional distribution system. And I think that is part of what helps. Most of our new agents are CPAs, attorneys, former bank trust officers, or had other business experiences, and we train them from the start in the DI business.

One of the advantages of being a smaller company is our underwriters can know all of the producers. We have six underwriters, and they all know all the people who do DI with us. There's a relationship there; we know the agent; we know who we can trust. And, believe me, if we don't trust you, you won't be doing business with us anymore.

We have a very experienced underwriting staff. All of our underwriters work with both DI and life insurance, which are our two main product lines. They have a lot of experience in the business. We have periodically brought people in, but generally they're trained from within. Our field thinks, and I really have no way to evaluate this, that we have the toughest underwriters and the toughest underwriting standards for DI. I don't know whether that's true or not, but it's a pretty tough group. So you have to get in the front door, and that has not always been easy to do.

We're very conservative, although I think we could probably be more conservative, personally, on some of our testing criteria. We were one of the first companies to do blood testing on DI, and we have, in certain states, relatively low levels at which we will do blood testing. California and Florida come to mind, and I think that's a standard practice in the industry. Personally, I think we could be doing blood testing at much lower levels, and economically justify the expense of the testing.

We're getting tax returns to verify income. One of the industry's biggest problems is when clients have overstated their income when they bought the policy.

We had a case that ended up in litigation involving a dentist. He put down his income as $300,000. Well, the gross receipts of his business office were $300,000. His income was about $60,000. And that's not an unusual scenario.

Now there's a situation where the agent can help you or hurt you. The agent is the only person who sees the client until claim time, and it's too late by then. So the agent can help you, or the agent can kill you. Part of this is a relationship issue we have with our field, and generally it's very good.

Another example of something where I think we're more conservative than a lot of companies in the underwriting area has to do with the issue of psychiatric treatment. As I trust you're all aware, mental-nervous disorders are a very substantial portion of disability claims, especially in California. If you've had any psychiatric treatment or if you're undergoing psychiatric treatment, you won't get a policy from us. A number of companies will issue policies with certain endorsements or riders on them, and we don't do that. And we do not think that you can ride out psychiatric problems. They manifest themselves in other ways, and you're going to get higher claims. And our field is not always happy with us on that, but that's the stance we've taken.

Another area in which we're different from a lot of companies is that we do not do any guaranteed issue business. We don't deal with associations where you really do have to have some kind of guaranteed issue program.

I still haven't quite figured out the logic behind a guaranteed issue contract with little or no underwriting, and a fixed price with extremely rich benefits. Perhaps with the exception of single premium annuities, I don't believe the industry is selling any other product where the price is fixed at issue. The risk is substantial, and there's no real ability to change the price later.

And to issue such a contract with no underwriting seems to me to be a big mistake. Some companies continue to do it and have presumably found ways to manage it, but I think there are companies that have really gotten hammered, that are no longer in the DI business, that were aggressively trying to capture a market share by doing this kind of business.

The issue of market share brings me to something that you may have already wondered, and that is, if your underwriting is tough and you do this and you do that, how is it that you can keep selling DI? I think one of the things that we decided long ago is that we have to manage this business well. We're not big enough to do it badly, and as it's turned out, nobody is big enough to do it badly. And so we've been willing to accept declining sales, and that's something that I'm not sure that many companies have been willing to do. Our sales are lower today than they were five years ago.

It was interesting to look at the first chart that Dave Scarlett put up: profits in the early 1980s and then profits falling off the table starting in 1987. Well, if you looked at our sales figures, profits were growing in the early 1980s. In 1987, profits fell off

the table. And we've been willing to accept that situation because we have to be very careful with this business.

In the other area of claim management, we are tough but fair. Obviously, we have contracts. We're a mutual company. We have responsibilities to our policyholders. We also have responsibilities to not pay claims when we shouldn't. We have responsibilities to the rest of our policyowners to carefully differentiate between what's appropriate and what's not. If we feel that we have a claim we shouldn't pay, we're not going to pay it. We're not afraid of our distribution system. We're not afraid to state that we're not going to pay a claim. And we're not afraid to litigate or get into a situation where there's an argument if we think we're right.

As a result of that, we do have more claim administration expenses and legal expenses as a percentage of premium than some other companies. Again, we're not trying to be unfair, but I think you have to be very aggressive on the claim side in managing this business, or else you're really going to get killed.

I have a couple of general comments. And this goes back a little bit to the culture of the company. I hate to use the word "never." I work with enough attorneys to know you shouldn't say never about anything. But the senior management of our company does not interfere with either the underwriting or the claim process at all. I've worked with our claim people and underwriters for probably 15 years, and neither area has ever been told by senior management, issue this policy, or pay this claim.

When the management of the company interferes with the professional judgment of the underwriter or the claim person, you do two things. One is you probably pay a claim or issue a policy you shouldn't. And the second is, you just undermine the confidence of the underwriter or the claim person. What's going to happen the next time a case like that comes in is the person is not going to want the president at his or her desk whacking the person over the head with a stick. The underwriter is going to issue the policy, and the same thing will happen on the claim side.

Our underwriters and claim people know this. Our field understands that. They don't call the president to get him to go down and change the minds of the line people.

Again, we've decided that, if we see things that the industry is doing that we don't think makes sense, we're not going to do them.

I think the guaranteed issue and the association decision was one that has clearly hurt us on the sales side, but we're still here. And a lot of the companies that, I guess, I'll say "blindly" followed the big companies in this area, are no longer in the business.

And part of my responsibility is to make sure that not only are we in the business tomorrow, but also we're in the business long after I leave. We try to manage the business conservatively, and perhaps that's an advantage of being a mutual company. I don't have quite as many people looking over my shoulder every three months.

I think we have a relatively conservative approach to the business. We've essentially been doing the same thing for twenty years. The business got a lot more aggressive

in the 1980s, and now it's getting a lot more conservative. And in some ways, it's coming back to where we've been all along.

MR. JOHN S. CATHCART: My question is for Mr. Palmer. You commented that you had been willing to accept decreases in sales over the past several years, since the late 1980s. Is there something specific that you might see in the industry that would cause you to want to pursue a more aggressive sales growth strategy? And if so, what would that be?

MR. PALMER: While we've been willing to accept declining sales, we're not happy about it.

I think that part of what will help us is to have the economy to improve a bit. The whole market for individual DI is off in 1994. It was off in 1993. So I think the economy coming back is going to have to happen for our sales and the industry sales to move up.

One of the other things that's hurting individual DI sales is that group LTD has really intruded dramatically over the last ten years on what used to be individual sales. The size of groups has gone from 50 or more ten years ago to a two-life group. It doesn't make a lot of sense, but it's what's going on. So I think you're going to see a shifting of business away from noncancelable to small group LTD in the small business markets.

But one of the things that's hurt our sales recently has been all the health care debate. We sell insurance to a lot of small business owners, and they're wondering if they're all of a sudden going to have to pay 80% of the premium for health care and pick up an expense that they don't have currently. So I suspect that, until that's resolved, the real small business market is not going to run around buying a lot of noncancelable DI.

The market has raised prices, and that will help from a premium point of view. Obviously, it will help from a profitability point of view.

MR. CLAYTON A. CARDINAL: I'd like a clarification on the Northwestern Mutual experience. When you did the waiver study on life, did you subdivide policyholders into those who had a related DI policy and those who did not? And if you did, what was the comparative results?

MR. SIMBRO: The bottom line is, no, we didn't. I think that may have been the nearest thing to do, but the general thing we were looking for there was, we started from the perspective of looking at our waiver of premiums to see if, in general, they were at the right levels. So it was just in general a study of waiver experience.

The initial intent was not, quite honestly, to compare waiver to DI, but in looking at that, we realized that there had been an incredible consistency in waiver experience in total compared to DI in total. But, no, we didn't slice it that way.

MR. STEPHEN J. RULIS: My question is for Dave Libbey. Dave, one of the points that you had made was talking about managing claims proactively. And I guess

especially in the context of hearing all three speakers, I was wondering if there are any plan design components that you see as critical to being able to manage those claims proactively?

In particular, Dave Simbro talked a little bit about some of the high replacement ratios that are out there when you don't offset with social security. I'm wondering if that inhibits your ability to manage those claims, and get the rehabilitation resources and folks like that involved.

MR. LIBBEY: Well, the first part of an answer to that question is that clearly the changes in coverage provisions and issue and participation limits over the last decade have made it more difficult to manage claims. At the same time, we have found some things that can be done that can have a significant benefit.

An example of that is what we've been able to do with psychiatric claims. We found some real success in managing a claim by working directly with the physician providing the care, and the claimant, and a home-office-based psychiatrically trained individual.

I think in terms of things that could be done, either have been done or could be done to benefit provisions. There are a number of things that might be possible. A limitation on the length of mental and nervous claims is an example of something that would make it easier to manage claims. That's one clear-cut example.

There are some aspects of specialty letters in the occupational rider that, in my opinion, have just gone a little bit too far and have created situations in which it was very difficult to get a person off of a claim.

MR. ANDREW M. PERKINS: Howell, I think you made a comment about measuring experience by agent, and I'm curious whether any of you have comments about the effectiveness of measuring, and also whether it's credible to try to measure, experience by agent claim experience as well as persistency experience?

MR. PALMER: You're right. In fact, as a general comment, one of the disadvantages of being a small company is that, once you chop the data up into more than a few pieces, you really don't have a lot of credibility even at a bigger scale than at the agent level.

We're looking for more abusive situations, if we see a lot of early claims from a particular producer. But we don't go in and say, your morbidity ratio is 85% this year, you're fired. None of our producers are doing enough DI individually that you would ever get enough credible data to really reward or penalize them for morbidity. We do reward and penalize financially for persistency through bonus programs.

We're really more looking for behavior that you would consider to be out of bounds, if you will. And again, one of the advantages of being small is that it's not really hard for our claim people to notice this kind of behavior. It might get lost a little more in the shuffle of a bigger company.

MR. LIBBEY: In addition to watching specific claim-related statistics on individual agents or producers, we also identified a number of factors that we believe characterize good business. And we can watch every policy coming into the company and measure those factors for that policy. And if we find producers who are predominantly writing business that is at the poor end of that scale, we do something about it. If we find producers predominantly at the top end of the scale, we tell them we like them.

We go through an annual producer review process where we look at claim and persistency statistics for all our producers. We use those statistics to float problem producers to the top of a list, which gets extensive review.

Our claim folks watch very carefully for quick claims on brand new recently issued policies. We track claims occurring in the contestable period. We have a lot of discussion on individual claim situations, including the producer and what the role of the producer was in selling the policy between the claim and the underwriting areas, as well as the market and the sales side. So large though we may be, we spend a lot of time on this.

I said in my comments that the field was critical to underwriting for a profit. Probably the single most critical thing you can concentrate on in the DI business is having your producers do what you want them to do.

MR. SIMBRO: To date, maybe the biggest value we've seen out of monitoring specific agents' loss ratios, and we focus on very recently written business, is just the fact that we've been monitoring the loss ratios and publishing them, and making agents aware of where they stand. This heightens the awareness.

The agents are concerned about the issue. For some, it's created a bit of an embarrassment, but it has also created a situation where agents are motivated to change their behavior just because of the fact that they've been made aware of where they stand.

As far as the statistical credibility, because of our desire to get a simple formula that everyone can understand, it's such a high threshold that it's extremely hard for any agent to get into that "problem" category.

The fact that the threshold is out there has been beneficial. And we are considering varying our measure to make it a little more specific to the model volume of business agents bring in. And we do have dramatically different volumes of business coming from different agents.

MR. LIBBEY: I have one more quick comment about that. Dave mentioned a key point, and that's communicating and involving the field in the process. We, as well, tell our office managers who's doing well and who's not.

In addition, we try to provide specific guidance to an office manager that says, if you can get your producer to do these three things, it will help move the block of business that you're underwriting out of the poor category into the good or the top category.

So not only do we tell them when they're not doing well, but also we try to tell them how to fix it. And we've seen clear evidence that providing that type of feedback to our office managers really pays off.

MR. SCARLETT: *Let me give a jump ball to the panel, and any of you who wants to* answer this question, just go right ahead. Some of you may be aware that there's an American Academy of Actuaries task force that's looking into risk-based capital (RBC) for health organizations. And the task force members just released a very preliminary report to the NAIC that indicates that RBC for DI, both individual DI and group LTD ought to be a lot higher. In fact, they're suggesting that it should be 55% of premium, plus another 10% loading on top of that for noncancelable, taking noncancelable up to 60.5% of premium, if I understand it correctly.

The proposal then goes to 30% of claim reserves for smaller companies that have 250 claims or less on the books, grading down to 12% of claim reserves for those companies that have 1,000 or more claims on the books. What do you think the effect of those RBC requirements might be on the industry, and what effect will it have on your companies?

MR. LIBBEY: Dave was talking about the C-2 component of the RBC formula for DI. The current formula is 35% of the first $50 million of premium and 15% of the excess, plus 5% of claim reserves. I'm speaking here to individual DI.

So with a little bit of quick math, for a block of business, at the marginal rate on premium, you can see that we're quadrupling the DI premium factor, and more than doubling the claim reserve factor.

It's fair to say that such a proposal, if put in place, would have a dramatic impact on the DI industry. It will certainly raise issues from a profitability point of view, thinking in terms of a company being able to achieve a respectable rate of return on its investment in the business. It will create issues as companies necessarily try to respond, let's say, by increasing premiums. It creates a conflict between the minimum loss ratio regulations and the required surplus requirements.

So I suspect that over the next few months the discussion on this topic is going to need to be to the point and prompt in order to come to a landing on where the RBC factors ought to be.

My understanding of what took place at the NAIC meeting in Baltimore is that the Other Health Organization Working Group, which is one of three such working groups within the NAIC RBC Committee, in effect, has decided that it is going to replace the existing requirements with whatever comes out of the process that's underway today.

It's an interesting development given that there are two other RBC working groups—one for life companies and one for property & casualty (P&C)—who must be wondering what it is they're supposed to be doing.

MR. PALMER: I think the impact of it, obviously, varies dramatically by company. If this actually gets played out, Paul Revere has, obviously, a very substantial block of business that would be impacted.

The DI business for us is about 15% of our total premium. These would have a very substantial effect on our RBC ratio.

I'm involved on the ACLI Actuarial Committee, and we've reviewed some other proposed changes to the formulas, which primarily are in the mortgage area. I think that those changes, relative to this change, would be viewed as tinkering with the formula.

This is a very material change to a formula that's literally only been in place for a few months. We will undermine a lot of the credibility of the whole process if we throw in a dramatic change so soon after the formula, which took several years to develop, was put in place. I think that's a big mistake.

And the rating agencies are now tying into these formulas and using them to assess company strength and if all of a sudden a company's ratio drops from 200% to 150%, or 200% to 125% because of formula change, I think that's a serious problem. And I hope it is given a lot more public discussion and a lot more research that I suspect that it has been given so far.

FROM THE FLOOR: I want to follow up on this issue. Do you know what the basis of this recommendation is? What confidence level were the researchers looking to achieve to prevent insolvency by this ratio, these factors? And who were the contributing companies that lent their experience, if any? And if none, don't you think this may not be a significant act of irresponsibility by actuaries?

MR. LIBBEY: I believe that research was done by the Academy task force supporting the Other Health Organizations Working Group. I don't know the extent of it. I have only very preliminary information as to the confidence level that was the target. And very little information about the techniques that were used to actually develop this proposal.

I'm not sure what disability companies have had input into the process up to the point where the report was submitted to the NAIC subcommittee. But I know that Paul Revere certainly did not. And I know that in contrast to the process employed over the last several years to put in place the existing RBC formula, that we and many other companies had an opportunity to be much more significantly involved in the process than we have had today.

MR. THOMAS J. STOIBER: I'm one of the guys on this RBC committee. That's why I'm not going to say anything irresponsible. It's irresponsible not to do anything, to pretend that there is no level of solvency out there. The question is, what's the level it should be?

Commissioner Wilcox, who's an actuary, is in charge of this working group. He's giving a session at this meeting. I think that's where you have to ask these

questions. If you're really interested, you might want to go to Health Organization Solvency—Actuarial Issues, which Bill Bluhm is running on the whole topic.

This formula was driven by medical needs. There is no formula today for HMOs in many states. There is no reasonable formula between a P&C company and a life company that writes health insurance. There are two different formulas, so that's irresponsible as well. Because it's very difficult for the regulators to model this.

The Academy volunteered a group of people to help out the NAIC, and I think that was appropriate because otherwise the NAIC would have kind of gone on its own. This is hours worth of discussion, so I don't even want to try to attempt it.

There was the opportunity for one or two of the large DI companies to contribute in a short time frame. There's a whole lot of reasons why this thing was put together, and I don't want to address that, but I just thought this was worth a comment at this point.

But I do have one question. I have the feeling that when our next generation looks back on noncancelable DI it will say, why did anybody write this stuff? And you know there's no investor in the world that's interested to see who writes DI.

This is a line of business that is so frightening. I get the sense that, if one or two of the major writers go to sort of a combination, or kind of evolve away from the noncancelable into sort of a guaranteed renewable, maybe it's a five-year guarantee instead of a lifetime guarantee, you'll see a lot more companies get into this business and won't be so afraid of it.

Do you have any comments on the possibilities of noncancelable at least evolving more away from that? Howell, you mentioned LTD would steal your business away. You can change rates on LTD business, group LTD. So maybe we should write individual DI that's more guaranteed renewable rather than noncancelable.

MR. SIMBRO: My own company has, at various times, thought about that. In fact, I stumbled across a paper that somebody put together about 15 years ago, and that exact subject was, why aren't we in guaranteed renewable? A basic issue is that it's not the same as being in LTD. Like it or not, it takes a long time if you're in a guaranteed renewable environment to change your rates, and to put them at what you feel is the appropriate level, and to reach agreement with the states.

I think a real practical scenario is, if you got in the loss environment on a guaranteed renewable structure, the states would seriously bring into question what you feel are your surplus requirements and your needs for an adequate return, and you may still not meet your profit objectives in a guaranteed renewable environment. So I think, on a relative basis, you could cut your losses as opposed to a noncancelable product, but I don't think by itself that it's a panacea. I think there are other issues that may be much more beneficial for helping up profit than just having the ability to change rates.

So I think a practical scenario, if you got in that environment, is companies will be pressured all the more to cut the initial premium as bare bones as possible.

MR. PALMER: You have a significant difference between noncancelable and guaranteed renewable in the price, or else the buyer is going to choose the fully guaranteed contract. So I think whether it becomes a bigger player or not will depend on the premium levels.

To pick up on something that Dave just said, the regulators who look at loss ratios and premiums are different from the regulators who look at solvency. Within the same department, you will deal with people who are concerned about the price, and they don't care about your solvency concerns, profitability, or anything else. They're looking in isolation at what you filed, and that makes it pretty difficult.

I think you will see more guaranteed renewable. Obviously, a lot of companies have been burned with a fixed-premium contract. It will be a bigger part of the business 10 or 20 years from now, but it will be a slow evolution, I believe.

MR. LIBBEY: Dave and Howell have made most of the key points here, but I want to get back to one point. It concerns me to characterize noncancelable DI as a super-risky product. At the same time, I'll say that noncancelable DI clearly carries risk. It deserves to be managed well, and it deserves to be designed well.

But switching from noncancelable DI to guaranteed renewable DI is, it is my view, not the way to get there. The way to get there is to manage your block of business as carefully as possible. Know where your profit is coming from and where it's not coming from. And be able to act and make the decisions you need to make.

MR. LIBBEY: My guess is the comments that you heard from this group couldn't materially be different if we were talking about guaranteed renewable. You still have to have good feel, underwriting claim management, underwriting, statistical support, and smart product decisions.

Whether you can change the price ten or 20 years from now is, relatively speaking, secondary. You have to do the basics first, and the guaranteed nature of it is an element. If you do these other things wrong, it isn't going to make any difference.