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TRENDS IN GROUP PRODUCTS AND EXPERIENCE

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Panelists: MICK L. DIEDE
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Recorder: SUSAN J. MCQUILLIAN

Several actuaries will lead an interactive forum on trends in group products and experience.

MR. JEFFREY T. GAVLICK: The first speaker is Bob Hardin, a cohort of mine at Foster Higgins; he has been with Foster Higgins about one-and-a-half years; he spent the prior seven years as an employer consultant, and that is the perspective he's going to give in his talk. It will be highlighted by recently published results of the Foster Higgins' *National Survey of Employer-Sponsored Benefit Plans.*

Next we will hear from Mick Diede. Mick has been with Milliman & Robertson for the past six years; Milliman & Robertson is more of a carrier/provider consultant, so he will address recent health issues from that perspective. It should be an interesting contrast to go from the employer perspective to the carrier perspective. Mick is going to discuss the evolving structure of health and managed care products.

Third, we have Wayne Roberts, vice president of Standard Insurance Company who will discuss issues relating to the group disability market.

Before I turn it over to the panel, I'd like to mention just a couple more things. First, this is an interactive forum which means it's an actively moderated session. It also includes significant audience discussion, so you're not done. I hope you are prepared to help us out. We've built in plenty of time for your questions and comments as we go along.

MR. ROBERT B. HARDIN: As you know, Foster Higgins does an annual survey. We have for a number of years, and we work relatively hard at making sure that it properly represents health care costs. We get a little over 2,000 respondents. We made a change last year to try to weight the survey so that it accurately reflects the population of employers in the U.S. One of the problems is our client base tends to be larger employers. So we do a second study, or rather a second cut, looking at employers with over 500 lives. You're going to see that data.

For the first time since we've done this study, health care costs went down. I assume most of you knew that because the results appeared in *The Wall Street Journal* and *The New York Times.* To put that into perspective, here are the results in Charts 1 and 2. Is that what those of you who represent carriers are seeing in your business? Have you seen the dollars go down? This is 1994 data. How about 1995? We haven't done a 1995 study yet, but some of you have. Are you seeing these same kinds of things in 1995?

CHART 1
AVERAGE TOTAL HEALTH BENEFIT COST PER EMPLOYEE
TOTAL HEALTH BENEFIT COST PER EMPLOYEE DROPPED 1.9% IN 1994

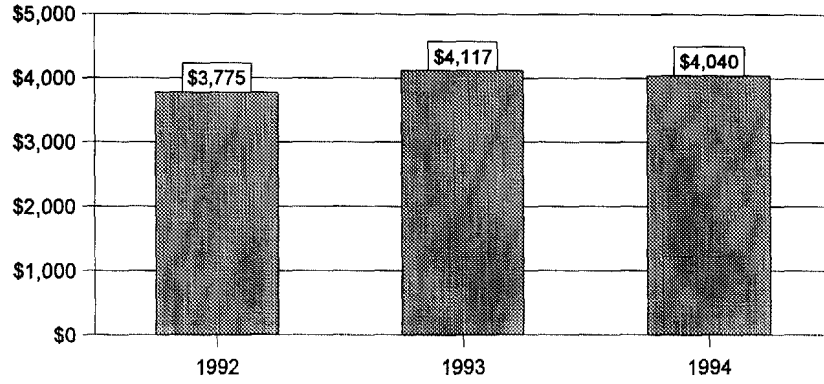
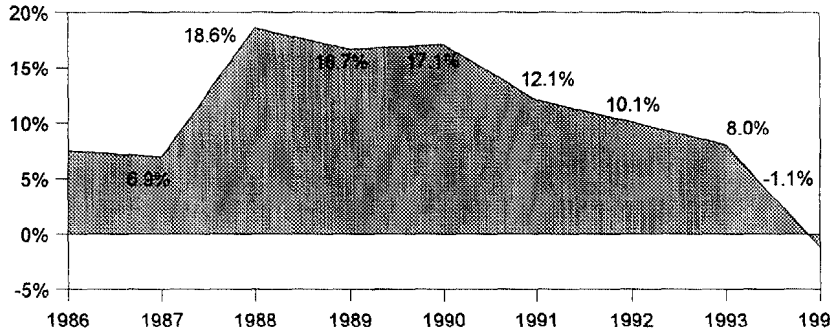


CHART 2
CHANGE IN TOTAL HEALTH BENEFIT COST PER EMPLOYEE 1986-94



MR. BRIAN G. SMALL: We saw that in 1994, but, you know, the hint in 1995 is they're going back up somewhat.

MR. JOSEPH T. FLYNN: I think that's heavily weighted toward the HMO incursion into the plans. But if you're working with a company that's not changing, I've seen cost go up, especially the fourth quarter of 1994, and 1995 looks like it's up again. There's very heavy usage in October, November, and December.

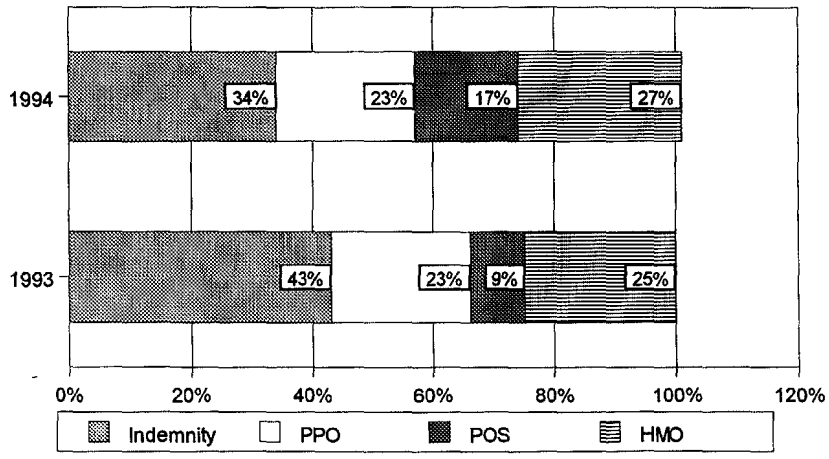
MR. HARDIN: What sort of numbers? Are you into double digits?

MR. FLYNN: No, it's single digits. It's somewhere around 7% or 8% in the last quarter of last year. It's about the same for the first quarter of this year.

MR. HARDIN: The Foster Higgins number is at some level misleading. Our study indicates that employer cost went down. In just a minute we'll show that some of the pieces of the employer cost did not go down. What really happened, based on our survey, is that many more employers used various kinds of managed care. Movement from traditional indemnity down the spectrum into HMOs or somewhere in between those two is what's driving the cost decrease. Also, the use of freestanding prescription drugs and mental health benefits is another big change that has affected costs. Furthermore, more retirees moved to managed care.

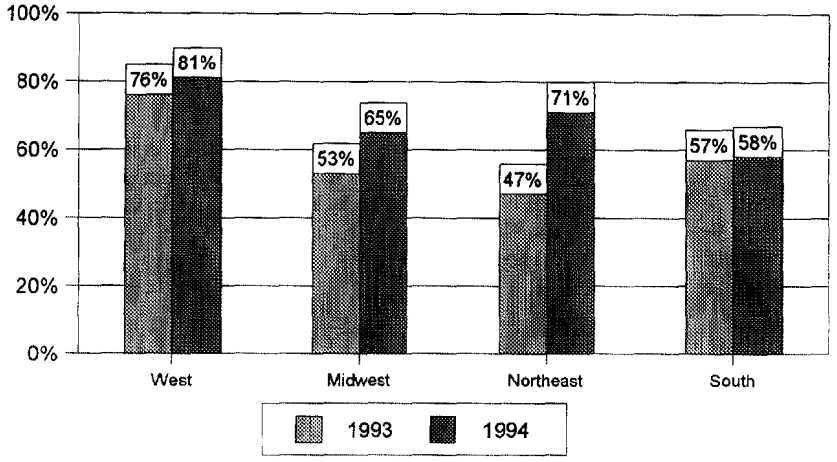
Chart 3 shows what has happened in terms of a shift in managed care from 1993 to 1994. Our survey says 43% of the people in 1993 were in indemnity plans. It's down to 34% in 1994. That seems like a huge number to us. Is that what other people are seeing? Is the indemnity plan a dying breed? Those of you who sell this kind of plan, can you say if it's been successful? Are you able to sell it?

CHART 3
PERCENT OF ELIGIBLE EMPLOYEES ENROLLED
PRIMARY REASON FOR COST DROP:
BIGGEST-EVER INCREASE IN MANAGED CARE ENROLLMENT



One of the things the survey showed was that there was a significant shift by region (Chart 4). Notice the Northeast. What our survey said was that much of what's driving this movement in managed care is what's happened in the Northeast. Maybe that was because in the West there wasn't any place to go, and we still aren't seeing new or big changes in the South. Anybody want to argue with any of these numbers? Does it seem incredible or unreasonable to you?

CHART 4
PERCENT OF EMPLOYEES ENROLLED IN SOME TYPE OF MANAGED CARE
MANAGED CARE GROWTH IS STRONGEST IN THE NORTHEAST



MR. GAVLICK: I was going to ask, if there's anybody that works in the South, if those numbers look right, and if there's any explanation for why there hasn't been much movement there. Anybody?

MS. SAMANTHA E. ENGEL: I think that has been somewhat true, but what we're starting to hear now from our field force is not only can we not sell indemnity in the South, we can't sell PPOs. There's definitely a push and in 1995, we'll probably work much more like the Northeast next year.

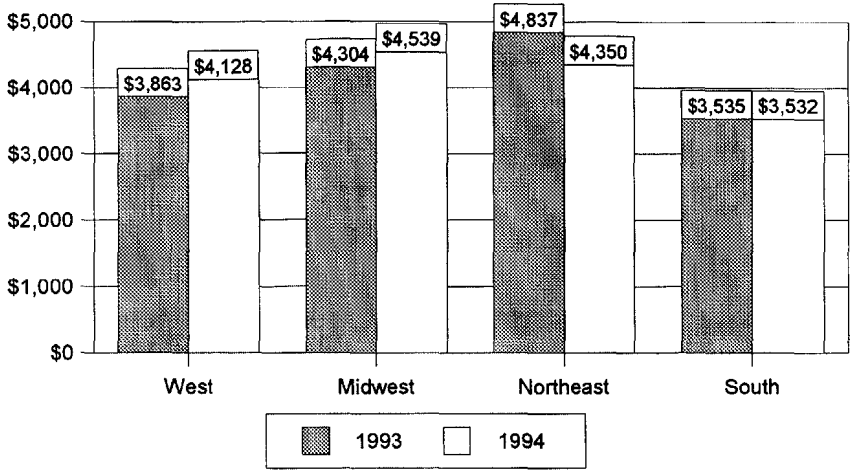
MR. HARDIN: The South is coming along.

MS. ENGEL: That's what they tell me.

MR. HARDIN: Parallel to that was a change in the cost by region (Chart 5). Again, we attribute the change in the cost in the Northeast, for example, to a change in managed care—the movement to managed care. For those of you who are in this business, does managed care really save dollars like this? Is this real?

MR. CABE W. CHADICK: I wanted to ask you what the benefit cost means. Is that just premium cost? The reason I ask is because it might be a perceived and demanded dropping of the rates. Does that translate into a continual movement because we're seeing that first time movement?

CHART 5
CHANGE IN BENEFIT COST BY REGION
THE DROP IN BENEFIT COST IS STRONGEST IN THE NORTHEAST



MR. HARDIN: Well, the answer to your question is, it's what we received in response to a survey question that said, "what are your costs?" And so for self-insured plans, as most of these are, these costs are going to be somebody's estimate—either the employer's or some consultant working for the employer. At the other end, in HMOs, I'm sure what we're seeing is premium numbers in response to the survey.

MR. CHADICK: The reason I ask that is, do you think there is anything to the idea that the first time they shift over to the new level of managed care they believe they are going to get this rate decrease? Is that what's being demanded in the market? They get it that one year they move over so that's why you're seeing these numbers on this one page.

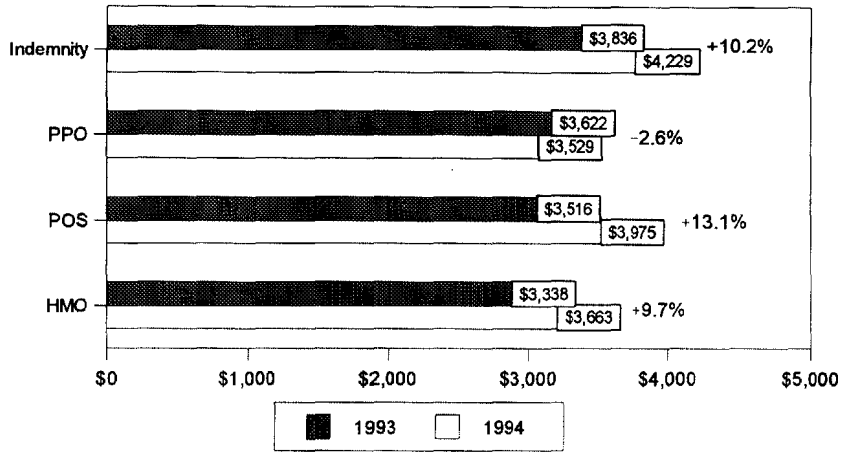
MR. HARDIN: I'm not sure I can understand your question. Was it something like, do we believe that this amounts to a loss leader kind of exercise?

MR. CHADICK: Yes.

MR. HARDIN: I don't have any evidence of that. I don't think so. I don't think our survey showed that was likely to be the case.

When we look at the cost by delivery mechanism, most of them went up, and not down (Chart 6). What this survey said was that while we did not get cost decreases by delivery vehicle, we had enough shift to managed care that we got a cost decrease. Do you believe that? I can tell you that there's a great deal of controversy, even among the people who did this survey, about whether what we've seen here is a statistical anomaly. We're looking forward, with interest, to see what we can learn in 1995. But it is, I believe, an accurate reflection of what our numbers said. Now, earlier, some of you said you saw decreases last year. Were you seeing decreases in indemnity plans?

CHART 6
AVERAGE COST PER EMPLOYEE
MEDICAL PLAN COST INCREASE AT DIFFERENT RATES IN 1994



MR. KEITH A. PASSWATER: I think this is an accurate reflection. The one thing that we haven't talked about, is how employers are asking for a leaner plan design, and that has helped really drive down their costs also. So that has also been a driving force.

MR. HARDIN: That's true here also. This does not reflect any plan change values. It's just the costs. So the extent that employers are moving to leaner plans gets reflected here and is not factored out.

MR. JAMIE MEYERS: With some of the HMOs I see a 10% growth rate, and that's very surprising to me. I would expect that has a great deal to do with the shift to the Northeast and the fact that the Northeast is starting from a higher base. What you see on the HMO side is that the weight is leaning more towards the Northeast.

MR. HARDIN: That's the Foster Higgins conventional answer to why did HMOs go up so much in this survey. It's because it's not apples to apples from 1993 to 1994. What we see is people like Oxford having a very good year in 1993.

MS. SUSAN COMSTOCK: I've recently joined Foundation Health. Within a short time I've seen in California employers letting you know at renewal time that they're looking for a rate decrease from the HMOs.

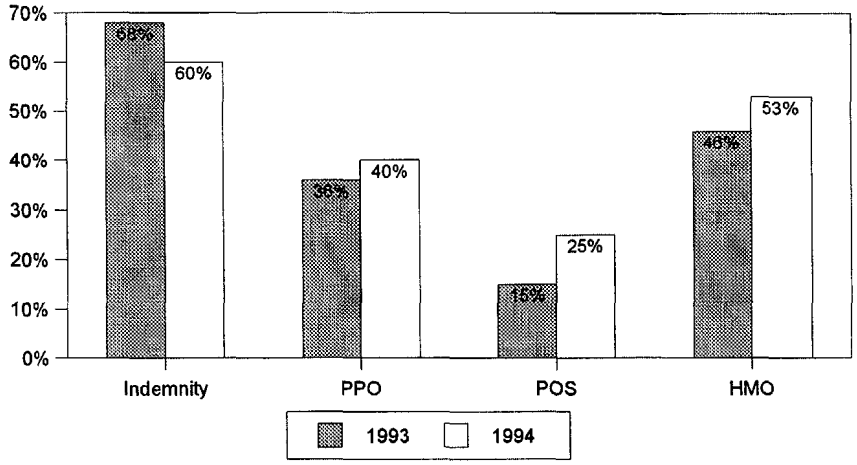
MR. HARDIN: That's my sense also from my own consulting. Employers are expecting HMOs to lower rates and, in fact, HMOs are doing it.

MR. GAVLICK: I think that HMOs are expecting that request.

MR. HARDIN: Right. Chart 7 shows what's happening in the employer market. This chart shows that last year, 68% of the employers offered an indemnity plan as at least one

of the options. It may be the only option. It's down to 60% this year. People who offered HMOs went from 46% to 53%. More and more employers are moving towards HMOs or point of service (POS) in some way. That's a quick executive summary of the financial results out of the Foster Higgins survey.

CHART 7
PERCENT OF EMPLOYERS OFFERING PLAN
MANY EMPLOYERS DROP INDEMNITY PLANS
TO MOVE EMPLOYEES INTO HMO AND POS PLANS



FROM THE FLOOR: Does this survey indicate if these employers are dropping their indemnity plans? How many are? They're going out there to that carrier and saying, I'd like to go into an HMO or PPO? How many are actually sort of being forced by their carrier into doing it? When the renewal time comes up they pretty much make it very unattractive to stay in indemnity and kind of force a PPO on them?

MR. HARDIN: I don't know the answer to that question. I'm sure that the movement is financially driven. Whether it's being driven by premium rates or costs are closely related kinds of questions.

MR. GAVLICK: My sense is that if an employer has a standard indemnity plan or has a substantial number of employees in the standard plan, and they want their carrier to bring the rate down in some fashion, one of the responses of the carrier would be, "Why don't you think about going to something managed and we can help you save money?"

MR. HARDIN: I think that's true of the large employer market; I think there's a number of employers who have said that the strategy is to move to managed care over time. Maybe we'll offer our POS plan this year, and next year the out-of-network benefit in the POS plan replaces the indemnity plan. Those kinds of strategies are not uncommon.

That's what I wanted to say in terms of health care trend, that is, changing cost from the employer's perspective. The other use of the word trend is fads; what are employers

doing? These are the items that I thought were of interest and where we're seeing relatively high levels of activity. More and more employers are offering long-term care—it's almost always employee paid. Certainly, there's a lot of talk about it. We're even seeing it here in our meetings as we release new valuation work. Are you people seeing long-term care? Is there much long-term care activity, or is it all talk?

We've seen several large employers in the Northeast move to something called life-cycle benefits that give you $10,000 over your career. You get $2,000 for your first house, $2,000 to put your kids through college, and so on. Anyway, my sense is that's highly publicized in a few large employers, but nothing's happening elsewhere. Anybody want to speak to that issue?

MR. GAVLICK: I could make a comment on long-term care. I don't know much about it myself, but I had the good fortune to travel on a plane across the aisle from Bob Darnell who knows quite a bit about it and he said that one of the long-term care issues right now, is one of taxation of benefits. Employers are offering it, I think, at full employee cost. Until there's any kind of a tax change making it a deductible contribution by the employer, there's not going to be any real action. So clearly, companies are lobbying pretty heavily to get that to be a tax deductible benefit. But until that happens, I don't think we're going to see much more than a sponsored employee-pay-all type of approach.

MR. HARDIN: And when that happens, you expect to see a sudden dramatic growth?

MR. GAVLICK: I don't know if I can characterize it that way. I don't know enough about it, but Bob sounded excited about it when we were talking, so I imagine it would.

MR. HARDIN: That's a good lead-in to the next item. We're seeing many large employers who have said, "I'm not going to increase my payroll costs anymore. I'm not going to increase my benefit cost. What I will do to make my employees happy is I'll find ways to do payroll deduction items." Employees pay the entire cost. Maybe the employer will absorb the administration cost. A large employer in Stamford is about to add group auto insurance as an alternative. I see a great deal of activity at carriers marketing that kind of program. Is property and casualty insurance a growth area for insurance companies over the next few years?

MR. GAVLICK: Do we have any insurance company product folks here? Maybe there are things not on this list that they can share with us.

MR. CHADICK: Our product development manager in ancillary lines is looking at that as a definite growth line for our company. I think he sees other companies doing it as well.

MR. HARDIN: The last item from the employer's perspective is we're seeing significant changes, particularly in the large employer market, as they get out of the benefits administration business. For the consulting view, this is a potential growth area. Employers stop administering benefits and hire us or our competitors or an insurance company, to administer their claims or administer their whole human resources (HR) operation. The employee calls up and the person who answers the telephone is the employee of a consulting firm or another third party rather than the HR organization.

I know that most of the large consulting firms are moving in that direction in one way or another; they hope to provide those services to large employers. As employers rightsize or downsize, they try to get out of the business or lower their head count. I think some employers are prepared to lower their head count whether it makes economic sense or not.

FROM THE FLOOR: How far down in an employer's size are you starting to see this interest in the payroll deduction?

MR. HARDIN: I work in the large group market and I don't know the answer to that question. Anybody want to answer it? My sense is it goes down pretty low. You know, there's no risk transfer. It stays with the insurance company. So the only reason it wouldn't go down to a small employer is because of the administration question.

MR. GAVLICK: There's one comment I wanted to make on outsourcing because it is a surprising but true. These employers are taking a large part of the human resources process and moving it outside of the company, to let's say, an expert, a consulting firm, or whatever. I found it to be a little shocking; but one rationale is that, again, because these consulting firms or these insurance companies are experts, they have the resources to track all the rules that are changing about human resource or benefit administration. Depending on the company, they're finding that it is actually somewhat cost-effective.

MR. ALAN N. FERGUSON: I just want to add to that. One of our companies last year took over a large employer. The employer had their own claim department. Our company didn't want to do that because they're going to have to revise their claim system and they didn't want to go through the reprogramming. All the systems work. So they contracted out the whole thing including the claims administration.

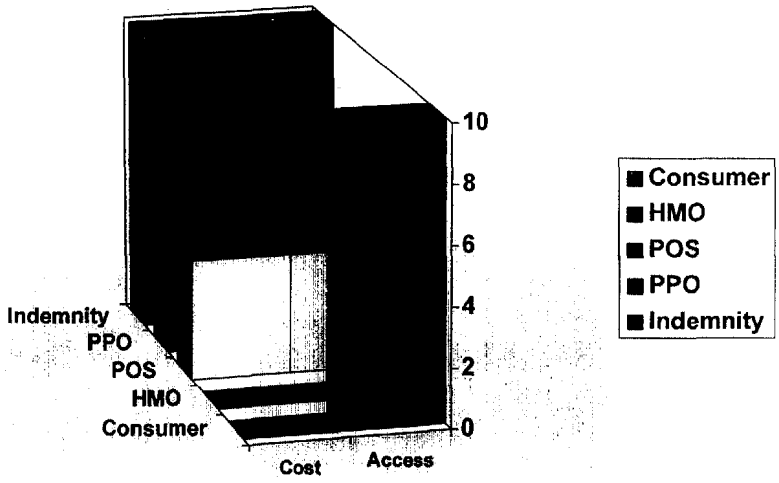
MR. MICK L. DIEDE: My segment is on experience trends from the perspective of providers and carriers. I'd like to cover three different topics here. First, I'd like to address general trends in product design. Next we'll show a few slides on developments in the provider contracting or development arena. Then finally, I'd admit that I've seen level or even negative trends in rates offered by HMOs. I want to talk about some of the drivers behind those.

Before we talk about recent trends and product design, I'd like to go back to recount a bit of history according to Mick. Chart 8 shows both cost and access on a scale of zero to ten, and it's intended to show total cost, including employee cost sharing. So as can be seen, the consumer pretty much expects everything for nothing. The HMO can deliver nothing for free. The indemnity carrier can deliver everything for everything. No small wonder then that in the 1980s we introduced new products to get at least closer to total consumer expectations. The indemnity carrier introduced a PPO product, which would restrict network access in total, but also provide for lower rates, while the HMO moved closer to that middle ground by introducing a POS product that would increase access, at some increased total cost.

In terms of new developments, I haven't seen much in the way of what I would call breakthrough product design similar to PPO and POS. Rather, we've seen much tinkering with the product designs. For almost all four types of product, I'd say there's been a continued trend in cost sharing between employers and employees. That can either be in

the form of increased contributions to buy coverage in the first place, or increased co-pays or cost sharing when you actually access medical care.

CHART 8
RECENT CPI TRENDS



Actually each of my POS product clients fall into one of two camps. Many seem to believe that POS is a good product in its own right, particularly because it might foster total replacement. Many of those are using a strategy that each tier of the POS product would be priced at fair actuarial value (so it really doesn't matter which tier an employee or member goes to at POS).

The other camp I've seen would be clients that believe that POS is really a "bridge" to get to an ultimate lock-in HMO product. And many of those carriers have introduced a lock-in HMO along side POS, often priced very aggressively. Would anybody care to dispute my recount of history, or talk about other product facets?

MR. GAVLICK: In this second camp, when they put in an HMO next to it, how has the experience gone? Where have people been going?

MR. DIEDE: The two that I'm thinking of have been fairly successful in getting a larger total penetration in the lock-in HMO than they had using the other approach. I don't think they've been very successful in getting total replacement in an HMO environment though.

MR. SMALL: When you refer to POS, is that a capitated environment or is it a mixture of both capitated and fee for service?

MR. DIEDE: I would say there's at least some capitation for primary care physicians, but not exclusively. It's very difficult inside a POS product to decide how to split up capitation dollars and structure incentives accordingly.

MR. MEYERS: We firmly believe that POS can be a viable end gain product and we've been pretty successful in it so far. Of course, we're still in our early stages, but we do think it's a viable option.

MR. DIEDE: While we haven't seen much in the way of breakthrough products, we have seen companies interested in diversifying or penetrating other markets. In particular, there has been a great deal of interest in Medicare risk products recently. These have been around for a long time, but we've seen a lot of activity recently and I think much of it's driven from the provider side where providers, particularly hospitals, realize that only 50% or more of all bed days in their given region are necessary and come to view Medicare patients (even at fairly low reimbursement rates per head) as valuable contributions to market share. Similarly, because of this, they're also willing to accept capitation or be more aggressive in risk assumption in order to protect the market share.

Similar forces are driving the use of Medicaid risk contracting in states where a waiver has been granted. Finally, lately there has been a flurry in the arena of Champus which provides care to dependents of active military personnel and also to retirees and their dependents. In fact, I'd say if we only had more actuaries in the country, Champus has all the makings for a blockbuster action adventure movie. First of all, there are big dollars involved. The average Champus contract will cover literally billions of dollars per contract period. Sometimes they will cover upwards of a billion dollars in a single state. Bidders are also expected to put significant capital on the table and be willing to lose it, often approaching $100 million over the course of the contract term.

The reform initiative targets the rates to go for five years, but gives the government the option to renew the contract each and every year. I guess those of you that worked in the California-Hawaii project also know that the government isn't the only one that can keep this one going out to bid every year. There are also very complex dynamics associated with this product. It essentially is a POS design, but it's further complicated by the fact that people can access care at military bases with no cost sharing whatsoever. To back this up, the government has introduced a risk formula that only an actuary can love, and even then only on a good day.

There are several distinct subpopulations to be evaluated. In some regions, a carrier won't have any managed care penetration, so it's hard to assume folks will be accessing an HMO. Some military bases have very high quality hospitals that can provide a lot of services. So there's the issue of projecting penetration rates at a site-specific level even though the total bid covers many states. Also, since costs have to be projected at the service level of detail, there's a real difference in expected costs between population segments for the maternity type services, particularly between the active duty dependents and the so-called retirees.

There's also a great deal of political intrigue there. There are successive updates to the bid specifications usually delivered under a tight timeframe. And, like I say, there has been litigation for three consecutive years in the California-Hawaii region. So to sum it up, this involves a great deal of risk; something actuaries like.

Moving now to the provider market trends. There was a session on this yesterday, but probably the most comprehensive trend I've been seeing is the increase in physician

hospital organization (PHO) formation, particularly in the Southeast. Several motivations are behind this, but almost all of my PHO clients claim they want direct access to the employers, throwing out the insurance companies or HMOs who they sometimes view as just adding needless overhead. I've seen a few PHOs that I think understand what's really involved in direct dealing and are poised to actually try something like that; for others it may just amount to beating on their chest.

Also, I guess a motivating factor for several PHOs seems to be defensive in nature. Just because one of the hospitals down the street has done it, they feel like they need to do it as well. And finally, one of the common reasons we hear is that managed care organizations want one stop shopping. A typical reaction from the managed care organizations has been, yes, we do want one stop shopping, but we wish you were closer to our neighborhood.

MR. GAVLICK: Do you think that these provider organizations have a lack of respect, a lack of understanding of what's involved in the administration, which they're finding out now?

MR. DIEDE: That's by far the most common outcome, particularly with respect to things like sales and marketing and contracting for out-of-network services. It is a very difficult problem for your average, community-based PHO. Just the idea of processing claims at the current procedural terminology (CPT-4) codes level of detail and actually getting to that level of detail and setting physician fee schedules is difficult. Many have put together very aggressive time tables for formation and just can't believe how long it actually takes to do this, let alone to do it well.

MR. GAVLICK: What do you predict will happen when they start running into these hurdles? Are they going to be able to start coming back? This is about trends. What do you think?

MR. DIEDE: It's hard for me to see that, over the long term, many of the PHOs that I've dealt with will be successful ultimately. I think many of them entered into it for defensive reasons. They're not looking to be aggressive and to manage medical care to generate empty inpatient beds. It doesn't seem like PHOs are poised for long-term success in this area.

The one thing that almost argues against PHO failure, like I said earlier, is this percentage of premium capitation reward approach that's becoming more common. I think you're accepting risk for premium setting as well as other risk; arguably, the carriers aren't providing as much value as they could be.

Again, capitation is not even close to new, but we've also seen an increase in provider willingness to accept capitation, and they're willing to accept more types of capitation deals. In terms of sheer numbers, there's still a lot of capitation of primary care physicians or physician groups. There's capitation of total physician costs through multipractices. We've also seen a lot of interest in hospital capitation or in global capitation.

Within PHOs, there has been an increased interest in specialty subcapitation, often at levels that don't even make sense to me. I've tried to talk a neurologist out of accepting

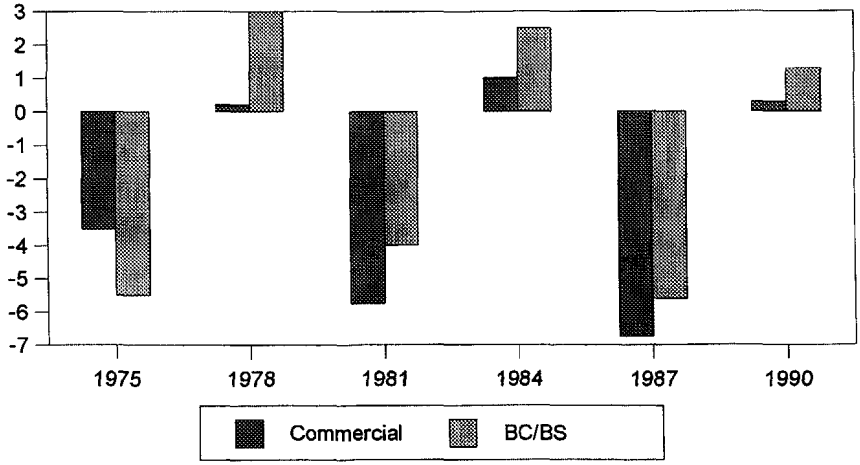
subcapitation claiming he needed something like 100,000 members to make this statistically viable, and he said he didn't care. He'd contract with 50 groups of 2,000 members and get to 100,000 eventually. He just wanted to go in that direction.

Finally, there seems to be a real increased interest on the provider side in disease management or total patient care. This makes a great deal of sense to me conceptually, but I think there are some real practical problems associated with it, particularly for an HMO that has hospital deals that cover all sorts of services. How do you go about carving out the facility piece for something like oncology when you contracted for that with an oncology group on a disease-specific basis?

The third segment of my carrier/provider perspective is drivers of HMO pricing aggressiveness. I've identified three subpoints. The first is general market conditions that have made this attractive over the last few years. Next, we'll go over contracting activities since it certainly relates to what we just talked about on the providers side. Finally, I've increased focus on the market.

I have a series of charts that we like to show our provider clients to help emphasize the point that there is potential for losses as well as rewards when you get into the insurance business, which essentially accepting capitation means. We also use this as a basic intelligence test to see which ones recognize that the chart gives out at about 1990 (Chart 9). For those that do, we show them another chart which shows the three-year underwriting cycle has been broken on the Blue Cross Blue Shield (BCBS) side, and I would guess the same is true for almost all HMOs as well.

CHART 9
COMMERCIAL AND BCBS UNDERWRITING
GAIN/LOSS



Certainly, one driver of profit has been the lower CPI trends. As was seen in Chart 8, they've been pretty favorable to all provider types over the recent past. While I don't

have a chart for it, clearly, the ability to reduce utilization days has also been a significant driver of pricing aggressiveness and profitability.

MR. GAVLICK: In 1995 is CPI starting to creep back up?

MR. DIEDE: I honestly don't know the answer to that, Jeff.

FROM THE FLOOR: In the first quarter of 1995 to the end of March, I think the medical CPI is running around 3.5%, which is the lowest it has been in seven years.

MR. DIEDE: Again, from a carrier perspective, capitation can allow a lower cost basis for care. What providers haven't been willing to accept in fee-for-service reimbursement they often will accept in a capitation deal. I don't really understand it, but it just seems to be true based on my experience. Certainly, capitation makes cost more predictable from a carrier's perspective which would allow a carrier to eliminate some of the pure risk component in its rating margins if anybody still uses that. It also provides an expectation, at least, that stable costs will extend out into the future, which helps multiyear rate guarantees that have become so common these days in some markets.

In states that don't have strict regulations, you can price the market much more quickly. Also, since you don't have to worry about negotiating specific dollar amounts each and every year, capitation is a great vehicle for long-term contracting. We've seen some contracts that extend for a period of ten years in the market.

The final segment I have is almost a new approach to developing rates. But I guess in order to understand the new approach, it's first important to recap the old approach. The old approach begins by looking at your actual experience period costs, and we're all pretty good at that. Next, you'd go out and talk to your folks in provider services and see what rates or levels of increase they might be able to negotiate in the coming year. You would also talk with utilization management (UM) personnel to see what utilization reductions might be expected.

The result of those two talks would be trend expectations that would apply to the experience period cost. It would allow you to set your renewal rates. Finally, you turn around and communicate those to marketing. I guess I left one step out of that process and that would be to pray. There are many things to worry about in this process. First of all, are the provider and UM folks telling you the truth? Second, can your marketing folks sell the rates you gave them? Third and probably, most important, can you keep your job for another year, assuming that you like it?

So as opposed to the old way of pricing, the new way of pricing that I've seen recently begins with the real focus on the market. The first step in that is to actually look at what employers are demanding by way of rate expectations. Then, back out your administrative cost to determine what's left over in claim amounts, or benefit costs, if you will. Allocate that to specific contracting funds, say hospital and physician to start with, and maybe finer degrees of separation for the physician categories. If you know your utilization and you know the total fund target, it's pretty straightforward to back into the implied reimbursement targets. You get to communicate them to your folks in provider services.

I guess I left out one other step on this one as well. Under the new approach you'd probably worry about exactly the same things that you would under the old approach, but probably in the reverse order.

MR. DEAN MARSHALL NELSON: You had a slide that showed the underwriting cycle incentive had been broken. Do you have any predictions on its future course?

MR. DIEDE: I guess I think the three-year underwriting cycle may be gone. I don't have any solid basis for saying that. I would expect results to be cyclical, but the cycle length will not be as regular as it has been in the past.

FROM THE FLOOR: I like your second approach there. Do you set the rates and then tell the provider contracting people that if you don't get them, you're going to lose money? Or do you say, here's what we want the rates to be? We're not going to set the rates until you get the contracts.

MR. DIEDE: Actually, I think both the new and the old approaches are sort of interactive that way. But there's probably more pressure on the providers under this new approach than there has been in the past. Some folks are reluctant to jump to the conclusion that provider services is going to hit those rates and automatically lower the rates. But there may be more real time reaction when it actually happens. You know, those contracts get signed, and the rates start going down immediately rather than waiting for the annual experience review.

MR. GAVLICK: I want to recognize Sue McQuillian, the recorder. Sue is an individual health actuary at Anthem Health Companies and a good friend of mine.

Our last presenter is Wayne Roberts with Standard Insurance. He has worked for a long time with disability issues and he's going to take us into some of those discussions. I think we'll find some of his facts interesting.

MR. WAYNE V. ROBERTS: I'm going to talk about LTD, new products, the outlook, underwriting changes, and claims management. I won't discuss reserves at all since there were a couple of other sessions on reserves.

As far as new products, voluntary LTD is being offered. Someone asked earlier, what size groups are voluntary products being offered to? We see groups all the way down to ten lives in the disability area and life insurance also. I don't think there's that much long-term disability being sold on a voluntary basis. Actually, we see more life insurance on a voluntary basis, but it is something that's piquing some interest. The second new product is a limited LTD benefit.

Another carrier is now offering a spouse LTD benefit and, just as you would expect, this would pay a benefit to your spouse if he or she is unable to perform some activities of daily living.

The next product is long-term care, and that's kind of a misnomer. This, again, is a product that's based upon activities of daily living. It increases the benefit from, like, 60%, to either 80% or 100% if you're unable to do one or two or five activities of daily

living. It's a limited benefit. So if you're flat on your back and you can't do anything, they actually pay a higher benefit for a while. There's a recent product being offered by a competitor. Here again, I don't think there are many sales in that area.

MR. GAVLICK: Wayne, on the spousal LTD, what's the benefit?

MR. ROBERTS: I believe you can choose amounts of insurance up to a certain level. If you have a spouse that's not working and staying home taking care of the household or perhaps babysitting, and if they're unable to do that and if you have to hire someone to get that work done, I would think there would be a demand and an insurable interest. We don't feel the demand is enough at Standard Insurance to develop the product at this time. We will wait and see if it will go anywhere.

In fact, the next item is 24-hour coverage. There has been much talk about 24-hour coverage in the last couple of years. I suspect if you ask a number of people what it means, you're going to get a number of different answers. To me, it's kind of the packaging of workers' compensation liability with medical and disability for both occupational and nonoccupational coverage. Put it all together in kind of a package and write it. There are some pilot projects going on. I know there's one in southern California and I know other larger groups are interested in trying to do something mainly on the medical side at this point in time. I suspect there will be more activity in that area.

The last item is a combined LTD and short-term disability (STD) product. There has been much talk about that in the last couple of years. We're talking about just combining the contract and the claim form to make it easier to administer. I still think the benefits are different, short-term disability is going to be paid weekly, and the long-term disability will be paid monthly. And maybe there's a preexisting condition that will apply to the long term and not the short term.

The interesting part of this one is your marketing people expect a discount if you write these two together. Actually, what happens is you have a long-term disability plan, and if you put a short-term disability plan in during the elimination period, it's not hard to figure out that you're going to get more usage. Now, if some other carrier has a short-term disability plan, you're probably better off having it yourself. So really you need three sets of rates. One rate, which is the highest rate, if somebody else has a short-term disability plan prior to your long-term disability because if you don't get the information, you can't manage the claims. The rate that's a little lower would be for the short-term disability plan. And, of course, the lowest cost would be if there's no disability benefit at all during the elimination period. But I'm not sure that's going to happen.

I mentioned a voluntary LTD. There's a 25% minimum enrollment. We have a preexisting condition exclusion as opposed to evidence of insurability. We have age-graded rates to help the selection potential. We use three different industry classes, and we actually exclude some industries from this product. Also, we don't have very many choices for a particular group. We just pick out a couple of popular plans and that's what they get. Either that or nothing. So I think that's fairly typical of what's being offered in the marketplace.

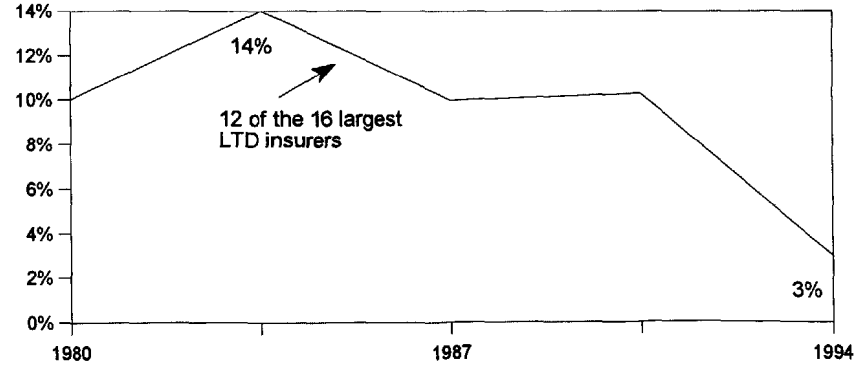
Another new product is a limited benefit LTD. We're calling this essential LTD. Basically, it has a choice of either a Social Security definition of disability after two years, or a two-year limit on certain conditions such as musculoskeletal disorders, chronic fatigue, chemical and environmental allergies, and some others. So for this, they get quite a discount if they'll put these restrictions in the contract, and we've actually seen this being something that's acceptable for some larger groups that have had poor experience, particularly, if they have a blue collar segment, getting a lot of back claims. Rather than increase the cost, they've shown some interest in putting a two-year limit on back claims. It's similar to mental and nervous restrictions that you have in the contracts now.

So what's the outlook for long-term disability? Right now, the profits are declining so if anybody is interested in getting into it, forget it. There's an increasing trend in claims. I'll talk about that later. There seem to be more competitors as people are getting out of the medical. They're concerned about national health care and they're looking for other lines. The only thing offsetting that is that there are still a large number of groups that do not have the insurance and so there is an increase in demand.

The next item is reducing profits. That's caused by more competitors. Also, we had a declining interest rate over the last few years and with long-term disability and reserves, the interest rate is very important. I also mentioned that we have an increasing number of claims for certain disabilities.

John Antliff does a survey every year of a number of the larger insurance companies and he has a chart that shows the profits of 12 of the 16 largest insurance companies (Chart 10). During the 1980s, profits were as high as 14%, and last year, in 1994, it dropped all the way down to 3%. I think you'll agree that probably doesn't meet your profit expectations.

CHART 10
HISTORICAL PERSPECTIVE ON DISABILITY PROFITS



We had some new disabilities crop up in the last five years (Table 1). Our experience is fairly similar to this. Men have a large increase in chronic fatigue, kidney disorders, carpal tunnel, back disorders, and AIDS. This is a five-year change. It's a little misleading and I'm not sure we did quite as good a job five years ago of classifying disabilities as we do now. If you look at the other class five years ago, it's probably a lot bigger than it is now.

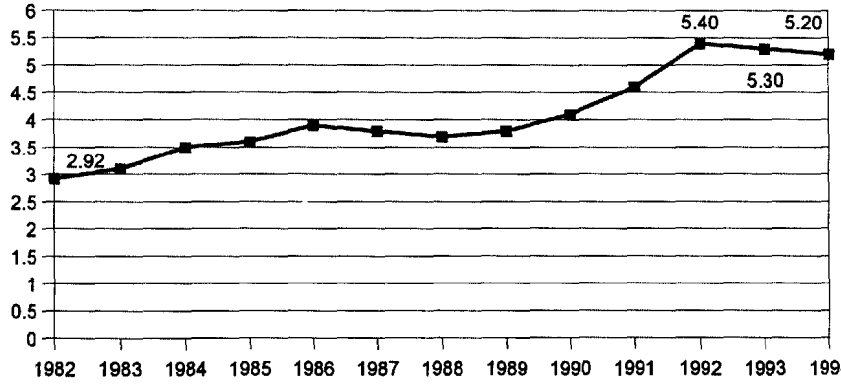
The right half shows women. Chronic fatigue and carpal tunnel show large increases as well.

TABLE 1
NEW ERA OF DISABILITIES

Disability	5-Year Change	Disability	5-Year Change
Men		Women	
Chronic fatigue	360%	Chronic fatigue	557%
Tendon disorders	453	Carpal tunnel	379
Carpal tunnel	386	Acute arthritis	350
Back disorders	180	Tendon disorders	239
AIDS	152	Osteoarthritis	199

Chart 11 shows the Social Security disability incidence rates. It's gone up from three per thousand to over five per thousand in the last ten years. That means one of two things. Either we have more people becoming disabled now than ten years ago, or Social Security is approving more of them now. Since Social Security is your deductible, the first alternative would mean that you should raise your rates. For the latter one, if they're approving more than they used to, then actually it could cause you to lower rates. So you need to look at your own incidence rates. Our incidence rates have not risen that much on a total basis. If you only look at doctors and lawyers, they certainly have gone up.

CHART 11
SOCIAL SECURITY DISABILITY INCIDENCE
CLAIMS PER 1,000 LIVES



Speaking of doctors and lawyers, I'll say some underwriting changes have taken place. As I mentioned, there has been deteriorating experience for the professional marketplace, particularly doctors and attorneys. Because of that, carriers have restricted benefit provisions. Actually, some carriers have pulled out of that marketplace entirely. Another thing some of the carriers are doing in an effort to reduce costs is they are asking the broker and the group if anybody has got a medical problem. I think more companies are now putting a drug and alcohol exclusion in their contracts, too. Since Social Security has

recently limited benefits for drug and alcohol to three years. That prompted some companies to make that change.

On the other hand, I think more blue collar groups are looking for coverage and that could be good or bad news depending upon whether your rates are appropriate for blue collar groups.

MR. GAVLICK: Could I ask a question about Table 1? Chronic fatigue had the highest growth. Can you explain? I'm not very familiar with that. What does that mean? Is it easy to get a disability with that qualification?

MR. ROBERTS: Well, chronic fatigue is hard to diagnose. It's kind of by exclusion. If somebody is tired all the time and can't work, the doctors will try to determine whether they have something else. And if they can't, it kind of falls into chronic fatigue. Now, if the Epstein-Barr virus is present, that will give some indication that they have chronic fatigue, but this is a very difficult claim. You also have to exclude mental disorders which may cause fatigue. There is definitely an increase in the number of claims.

I mentioned that the medical experience is getting worse. I think that's caused by fewer jobs, reducing incomes due to managed care, reduced stays in hospitals, more outpatient clinics, and nurses doing some of the work that doctors used to do. It's a combination of a number of things. Salaries are also going way down.

Of course, we did it to ourselves to some degree. We offer very liberal benefit provisions for the professional marketplace. There are high maximum benefits up to $25,000 or $35,000 a month. It has a high benefit percentage. We were offering a 70% of earnings on partnerships, which means the benefit is tax free. This means the partners were going to make a lot more being disabled than they actually were when working. We're now wondering why we have so many claims. We also use a very liberal definition of disability. If they're disabled from doing their own specialty, we pay benefits all the way to age 65. Many contracts were written without any mental and nervous limitation.

We took no consideration to what individual policies they might have. One thing that we're looking at now is writing a contract that will either deduct individual policies or at least integrate with them on a back-door basis. So we would try to prevent overinsuring. With these current benefit provisions, we made it very profitable for doctors to go out on a claim, and I think the burn out rate is catching up with some of them, and they're finding it very lucrative to "retire" early.

I mentioned claims management a little earlier. In answer to your earlier question. I think most companies are really looking to this area of trying to improve their claims management to reduce cost. We're doing more settlements, trying to get involved with earlier intervention, case management and the various things. John Hewitt put out a disability bulletin in May that talked about claims management.