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DREAD DISEASE INSURANCE: YESTERDAY, TODAY, AND TOMORROW

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This panel will discuss various product issues relating to dread disease products: features, cost levels, evolution, the future, the consumer and regulatory environment, and payroll deductions. The panel will describe the current products available in this market, with emphasis on cancer insurance.

MR. DON N. PATTERSON: I'll be introducing each speaker more extensively in a few moments. First, I would like to give a brief background on the topic. Dread disease insurance provides protection against treatment costs for cancer or other specific illnesses. Dread disease insurance is generally positioned as a supplement to broader life insurance and health insurance coverage. It is intended to relieve the stress from financial burdens that accompany the onset of the dread disease. Dread disease insurance has been the subject of consumerists' complaints that it is overpriced, unnecessary and subject to so many exclusions that a meaningful level of benefits is unlikely to be paid. It has also been charged that agents have sometimes used scare tactics to get people to buy the coverage.

David Arial will be the first speaker. David began his actuarial career in Los Angeles in 1964 and has been working for Colonial Life and Accident since 1969. He has been an FSA since 1979. David will speak on the features and benefits found in dread disease coverage and the evolution of the products.

Mark Shaw will be the second speaker. Mark has overall responsibility for the actuarial functions at the Capitol American Group of Companies. He began working on supplemental individual health insurance products in 1980. He has been a regular attendee and industry participant at the NAIC Life and Health Actuarial Committee meetings for over six years. He is currently a member of the Health Insurance Association of America (HIAA) Supplemental Insurance Committee and the HIAA Actuarial Technical Support Subcommittee. Mark will speak on the regulatory and consumerist environment and the return-of-premium benefit.

Curtiss Sheldon will be the last speaker. Curt joined American Heritage Life Insurance Company in 1993. He has more than 30 years of actuarial experience with companies and in consulting. He is a member of the Nontraditional Marketing Section Council of the SOA and is a past president of the Southeastern Actuaries Club. Curt will be speaking on rate increases and payroll deductions.

I am an actuary in Allstate's direct response business unit. We market accidental death and dismemberment, term insurance, hospital indemnity, and credit insurance to Sears, Discover, and Shell credit card customers. We have not yet entered the dread disease insurance market. Each speaker will also speak on the future of dread disease coverage.

MR. DAVID B. ARIAL: My company has been marketing cancer insurance since 1968. There have been a number of driving forces in the evolution of cancer benefits. Product competition by the various companies, and the number of companies that have been and are writing cancer insurance, have provided much of the change. Also, benefits mandated by the state has had a significant effect. Medical technology has changed dramatically since 1968 when Colonial began selling cancer insurance. We were certainly far from the first company selling cancer insurance.

Our first product was a very simple one, including a basic indemnity in hospital coverage in the amount of $30 a day for the first 30 days, a small ambulance fee, and a transportation fee (which was rarely used). You received all this for $1 per month; $2 for family coverage. That happened in 1968. By 1969, we had doubled those benefits, so for $2 per month you received $60 per day in the hospital. By the end of the 1960s and in the early 1970s, we had ten basic benefits—hospital confinement, drugs and medicine, surgery, attending physician, and so on. The one that probably has changed the most over the years is the radiation and chemotherapy benefit which had a maximum of $1,500 based on usual and customary charges.

In the late 1970s we had expanded that and we saw the first effects of HMOs, probably generated by the Kaiser-type program. We found many people who went to a hospital (because of the type of health insurance program they were in), were not incurring any expense. There wasn't any specific charge for a variety of the procedures that were being done. So the industry came up with a nonexpense-incurred hospital confinement benefit, so that if there wasn't an identifiable charge for the hospital stay, we would pay this benefit.

Convalescent care was introduced in the early 1970s, mainly because there were many cases where there wasn't much else that could be done for those with cancer. As part of the same product, the radiation and chemotherapy benefit was changed pretty much industry-wide to be on an actual charges basis. The lifetime limit of $2,500 on this benefit was usually exceeded even in the early 1970s.

This next product dates from about 1983. In this product we have the introduction of an initial payment, or initial diagnosis benefit, of $1,000 payable on diagnosis of internal cancer. There is also a progressive payment benefit of $40 a month. Every time you accrued another month's worth of coverage, the initial payment benefit would increase by $40. That was intended to promote persistency. The other benefits grew somewhat and were sometimes being refined, but there were only a few significant changes. Diagnosis of skin cancer was identified as a separate benefit to differentiate it from internal cancer. Radiation and chemotherapy was changed from a total lifetime maximum to $100 a day with no maximum number of treatments. Every day you got a treatment, you got a payment, but the limit was on a per-day basis. At that time, blood and plasma processing charges began to be more significant and were paid separately from the blood and plasma benefit itself. As part of the changes in mandated benefits, we introduced the prosthesis benefit. This is not a benefit that was customer-driven. It was done where various state insurance departments or legislatures required that if you're going to have a cancer policy, you had to have prosthesis coverage among other mandated benefits.

The next cancer product change dates from 1988, and provides an increasing level of coverage. The hospital confinement is up to $300 per day or $350 per day in some

situations. This product is significant due to a couple of its benefits. One is the wellness benefit, which is really a cancer screening benefit. Prior to this, when people had diagnostic procedures such as pap smears and mammograms, but no cancer was found, there was no payment made. This was one of the first policies that addressed the situation where a diagnostic test was made for cancer, and if no cancer was found, a benefit would be payable in any case.

It looked like these changes were coming fast and furious but, around the country in various companies, there was a great deal of debate. Also, there was some public debate, as Don has mentioned. But there was much more internal debate about whether you should do this, that, or the other. I'm happy to report that in my company the actuarial department won every debate, even though it did not win every election.

There is one benefit where I suppose the actuarial department won the debate but lost the election, and that is the radiation and chemotherapy benefit which became the amount you were charged. There was no lifetime limit. It also covered antinausea medication in addition to the actual chemotherapy treatment. The antinausea medication that was developed as part of the improving medical technology really made a great deal of difference. Obviously there was an increase in technology in the chemotherapy area and the antinausea medication meant that people could take much more and stronger treatments. In doing the usual actuarial stuff, we looked in the rear-view mirror and priced the radiation chemotherapy benefit on what used to happen. Since this was a period when things changed dramatically, this benefit was not one of the wisest, in terms of financial control, that we ever put in. We since have backed away from unlimited chemotherapy; you will not see it in the next product version.

The transportation and lodging benefit is not a big or significant benefit in terms of the cost or in terms of the benefits paid. But they are very important in terms of how cancer treatment can be incurred or received by the family. There are many situations where one person gets cancer in a family, but it really affects the whole family; there's a great deal of care that has to be provided. People want to be with somebody. Usually they cannot travel very well on their own to receive treatment. In many cases, especially among people living in smaller cities and in rural areas, there's a lot of transportation and overnight stays involved. So this benefit has been a very big selling point, and it is received very well by our customers.

The latest version of our cancer product has a much wider variety of benefits payable than the first products that we saw. The list of screening benefits we'll pay for is much more extensive, reflecting both the changes in the technology and which cancers can be tested for. The initial diagnosis benefit continues to increase. The radiation and chemotherapy benefit has been pulled back to some degree to reflect the problems that we have run into with an unlimited benefit. You can buy an unlimited rider that can be added. Many people do, but many people do not, so we've pulled back to $300 per day for the top benefit we'll pay, and any nausea medication is now a separate benefit.

There are a number of benefits, and many of these are done separately for clarity as well as to make sure we pay an appropriate amount. Benefits like second surgical opinion and reconstructive surgery are really the result of continued increases in mandated coverages. This is the first time we see an increase in the prosthesis benefit as well as a new bone

marrow donor benefit, which would be payable to the donor of bone marrow. Air ambulance is also a new benefit.

Clearly there has been a great deal of evolution and change. Probably what my company provides in terms of the number of benefits, the variety of benefits, the breadth of benefits compared to where we started from is very typical of most of the other competitors that we see in the cancer insurance business.

In terms of the future, all I can really say is that "the future isn't what it used to be." We're probably looking at the end of more and more benefits. In other words, we have close to 50 separate benefits within the cancer product that we're offering right now. It looks to us like it's going to get simpler before it gets more complex because it seems the salespeople and the customers may have reached the limit of what can be comprehended for what, in essence, is a supplemental, very simple type of sales situation.

In addition, I guess our view of the future is that whatever happens with health care reform the government and maybe insurance companies and HMOs will spend less on situations that are, in essence, deemed to be hopeless. This would apply to people who may need heroic efforts to stay alive, or where treatment for cancer, among other things, may be extensive and yet only extend life for a month or a year or a couple of weeks. We feel there will be many people who probably would want, because of their own personal beliefs or situations, to avail themselves of these heroic treatments. There might also be some cases that are just plain serious but there is a chance that the patient can get through; however, the insurance company or the government or whomever is paying may not be so inclined to continue to provide benefits. This is much like what we're seeing in Canada's medical system or Oregon's system where there's a limit to how much the taxpayers will put in. We think the future of supplemental medical type insurance, like cancer products, is probably along those lines where people make their own choice about their own money as to what sort of treatment they want to have for themselves and realize they have to pay for it out of their own pocket.

MR. MARK E. SHAW: I appreciate the opportunity to share with you the benefit of some of my experience with dread disease insurance. My comments are on the regulatory and consumerist's environment and return-of-premium benefits. I'll make just a few comments on the future as David has done.

Let's start with the regulatory and consumerist environment. This is really quite a timely discussion, because there are a number of activities that are going on this front. I think to understand the current environment, first, we need to review the regulatory history of dread disease insurance.

Special risk insurance, of which dread disease insurance is just one kind, has been around since the beginning of insurance time. Airline trip insurance is just a modern equivalent of safe voyage insurance, for example. Polio insurance was common in the pre-Jonas Salk days. Specialty risk insurance basically just parallels the concerns of the times. Today the most prevalent of this type of product is cancer insurance.

In the late 1960s and early 1970s, which was really the infant years of cancer insurance, it was inextricably bound up with mail-order accident and health insurance in the public's mind. Respected celebrities such as Art Linkletter and others pitched these things through

television and radio, while written advertisements boldly displayed their likenesses. However, problems abounded and the major complaints came from consumers who told of buying mail order insurance, only to later discover loopholes and small print, which basically denied the assertions made in bold print. Art Linkletter himself was widely criticized for promoting coverage that gave its policyholders much less than what was seemingly guaranteed in the advertisements. These problems in the mail order industry, rather than in the cancer insurance industry, were the fodder of public debates. And while not all mail order insurance was cancer insurance, cancer insurance ended up being tarred with the same brush that was applied to mail order.

Some of the questionable practices that existed then included: companies ignoring claims for unduly long time periods, intentionally delaying payments by sending out a continuous stream of forms that had to be completed before payments would be made, pre-existing condition clauses that were not uniform and were subject to misunderstanding and the deceptive advertising, which I already mentioned. These problems were addressed by a number of model laws that were adopted in the 1970s such as the "Rules Governing Advertisements of Accident and Sickness Insurance," "Individual Accident and Sickness Minimum Standards Act," and the "Uniform Individual Accident and Sickness Policy Provision Law." Also, in terms of dealing with the value of the policies, there was "Guidelines for Filing of Rates for Individual Health Insurance Forms."

Let's skip ahead many years to 1995. In May of 1995, Commissioner Glenn Pomeroy of North Dakota held public hearings on behalf of the NAIC to "solicit input from interested parties on what, if anything, should be done to modify the regulation of limited benefit plans." At those hearings, the Consumer's Union testified with the same basic themes they had in the 1970s and early 1980s:

1. Consumers need protection regardless of the type of illness they have.
2. Hospital indemnity and dread disease plans tend to be of low value.
3. Dread disease and hospital indemnity plans are unnecessary.
4. As a nation we need public policies that make the most efficient use of our health care dollars.
5. Millions of seniors buy this low-value coverage.

There was only one other consumerist that testified and that was one representing the California HICAP, and she basically dredged up the same past issues and cited loss ratios and advertising as current concerns.

The industry testified at the hearing and, in my opinion, did a good job of responding to the various consumerist points. Things that were specifically pointed out include:

1. Everybody agrees that people need protection, regardless of the type of illness they have. Studies show that the overwhelming majority, something in excess of 80%, of those who purchase dread disease or hospital indemnity insurance have other comprehensive insurance.

2. One objective measure of planned value is loss ratios. Limited benefit plans including dread disease and hospital indemnity plans are generally subject to the same loss ratio rules that apply to other medical and disability insurance with the exception of some appropriate adjustments to account for differences in average

premium size. Other indications of value that were mentioned were the thousands of testimonial letters that the sellers of such policies have received.

3. Consumerists argued that dread disease and hospital indemnity plans are unnecessary because they're duplicative and they pay benefits based on medical events that are substantially paid for by other insurance. What they fail to acknowledge is that these plans are not sold on the basis that they will pay for these medical events themselves, but rather on the basis that benefits can be used to pay for sometimes substantial out-of-pocket expenses that accompany the occurrence of a dread disease. These out-of-pocket expenses may include not only deductibles and co-payments, but loss of income, transportation expenses to special treatment centers, assisted living expenses, and so on.

4. With regard to public policies and the best use of premium dollars, the primary point that was made is, since when is it good public policy to restrict consumer choice? Is it a poor choice for someone to use supplemental insurance as a hedge against what could otherwise be financially devastating? A study published in the December 21, 1994 issue of *The Journal of the American Medical Association* entitled, "The Impact of Serious Illness on Patients' Families," concludes that a significant percentage of families experienced severe financial burdens as a consequence of serious illness even when they had comprehensive health insurance.

5. While many seniors may purchase dread disease and hospital indemnity plans, they are not the target of such sales. The largest marketer of such policies testified in the hearing that the average age of purchasers was in the low 40s. This is consistent with the experience of my company. As for the seniors that do buy, should they be denied that right? Since a greater percentage of them live on a fixed income, isn't it even more rational for them to buy an additional policy that would help buffer the cost of serious illness?

Finally, these policies continue to be subject to the substantial consumer protections that I've already mentioned that were adopted in the 1970s and early 1980s.

Despite the fact that, in my view, the hearing presented no new evidence that sellers are guilty of any major infringements on the public, the NAIC acted at an executive committee meeting in July and provisionally approved, subject to a fiscal impact study by the executive committee of the NAIC at its next meeting, establishment of a limited benefits working group under the Accident and Health (B) Committee of the NAIC. The charges to the working group are the following:

1. "Study and evaluate limited benefit plans for life and health insurance, and the necessity for special regulation of these products and how they work in the marketplace, whether they duplicate coverage for some consumers who purchase these products and whether the consumers obtain reasonable value for the premium in relation to the benefits obtained;

2. Establish standards as appropriate for limited benefit plans of life and health insurance and facilitate public understanding and comparison of these policies; provide for disclosure in the marketing of this coverage; protect consumers from

> unfair or deceptive practices in the marketing of this coverage; and provide fair pricing of these policies to the policyholder. Report by the 1996 national meeting with a proposed model law deemed appropriate."

At the recent fall meeting of the NAIC in Philadelphia, the new limited benefits working group met for the first time. They had time only to review their charges, decide that they needed to compile information on existing laws and regulations relative to such plans for their next meeting and talk about the timetable they had set, which as I just mentioned, calls for a new model law to be finished by December 1996, so that the plenary of the NAIC might have a chance to vote on it in March 1997.

So far I've only spoken of broad level NAIC regulatory activities. State regulation of dread disease products has been, with few exceptions, relatively static since the early 1980s. Let me just mention a couple of states where that has not been the case.

First, in 1990, Minnesota adopted new loss-ratio rules relative to limited benefit products. The loss ratios for individual policies were initially set at 65% and were scheduled to increase 1% a year until they exceeded 70%. The loss ratios for group policies and certificates were set 10% higher. As a result of this legislation, sales of such products in Minnesota decreased dramatically. In fact, I'm told that the volume for major writers of the products dropped to about one third of the previous volume. There was also a significant outcry from the public about the lack of availability of such products in the state. I'm happy to report that, just in the past year, Minnesota has repealed the prior law and instead adopted new loss-ratio requirements that mirror those submitted in December 1993, by the Life and Health Actuarial Working Group to the (B) committee of the NAIC. Those requirements can be described generally as 65% for guaranteed renewable and 60% for noncancelable after a $30 per person insured exclusion for expenses with the resulting loss ratio not being less than 10% lower than it otherwise would have been before the exclusion.

The second state that I'd like to mention is West Virginia. West Virginia adopted a new law in 1993, that is also directed towards limited benefit plans. This law required refunds if a loss ratio in a given experience period did not exceed certain thresholds. The industry had several problems with the law and its interpretation by the department. First, the law purported to apply not only to contracts that were issued after its effective date, but also to all in-force contracts. This was widely viewed by companies as unfair, given that they had already incurred expenses at given levels based on certain anticipated loss ratios and now might be precluded from recouping such expenses if they had to comply with higher loss ratios. In addition, more than one company argued that the retroactivity element of the law was unconstitutional.

Second, the law took an expansive view of what a limited benefit plan was. A sore spot for industry was that disability income was included in that definition. Finally, and perhaps most disturbing is that the department took what was widely viewed as an actuarially unsound position to the definition of what it meant to incur a loss ratio in an experience period. They essentially took the position of "cash out versus cash in" with no recognition for changes in reserves of any kind. If strictly held, this would mean that level premium products could not be sold. Such products would be priced on a term basis. Products that incorporated a deferred benefit of any kind, such as the building benefit that David mentioned or a return-of-premium benefit, would also be eliminated.

In the 1995 West Virginia legislative session, there was some reform that has caused what may be an uneasy truce. First, the definition of limited benefit plans has been reformed so that disability income is no longer considered a limited benefit plan. Second, although the constitutional issue has not been addressed, the refund threshold for contracts sold prior to the law's effective date has been lowered to the filed ratio for those products less 5%. This leaves the remaining issue of reserves. Although the new law is silent on reserves, the industry believes that the legislative history now supports the use of such reserves as the originally revised legislation had wording that would have prevented these reserves and that was deleted from the final approved bill. I should mention that the department does not necessarily agree with that final point.

The next subject I'd like to talk about is return of premium. Like cancer insurance, return-of-premium benefits have a somewhat checkered regulatory history. In the 1960s, there was a company that sold primarily disability income policies with return-of-premium benefits to airline pilots. The company went bankrupt and caused as much of a stir back then as either Mutual Benefit or Kentucky Central did in recent times. The company's bankruptcy cannot be attributed solely to return of premium. The definition of disability for the pilots was loss of license, for whatever reason. Thus, for example, if a pilot lost his license for drinking alcohol within the restricted period prior to flight, he became permanently disabled. So it had extremely high disability claims. The profitability issues this caused were compounded by the fact that it had exceptional persistency on those that did not become disabled, so basically it had lose/lose experience that led to their bankruptcy.

Largely as a result of this, an NAIC model was developed for nonforfeiture benefits in accident and health policies. This model, which has been since archived and is not currently recommended by the NAIC, is the primary basis for most of the laws that have existed concerning return-of-premium benefits since the 1970s.

There has been some state activity in recent times that mostly favors allowing such benefits. In the 1990s, we have seen laws adopted in Minnesota, South Carolina, and Utah, among others, that have allowed such benefits in individual policies for the first time. Additionally, Pennsylvania has adopted rules permitting such benefits with disability income and specified disease products. There have been states, such as Indiana, that have repealed previous restrictions on such benefits.

Let me just mention some of the reasons behind return-of-premium benefits in dread disease policies. If consumers buy a life or a comprehensive health policy, they know with near certainty that by simply continuing to keep their policy in force, they or their beneficiaries will collect a benefit under the policy. The same cannot be said of disability income, specified disease or any other limited benefit policy. While such policies are of vital importance to those individuals who are unfortunate enough to suffer the contingent event upon which the policies are predicated, without a return-of-premium provision, those who are fortunate enough to escape such contingent events may never receive any benefits from their policies, regardless of how many years they pay premiums. The primary purpose of return-of-premium benefits, then, is to allow those consumers who desire coverage, who would not be content with the possibility of never receiving any benefit from their policy, the opportunity to pay somewhat higher premiums. These higher premiums would guarantee, by keeping their policy in force, the eventual receipt of benefits.

Other purposes accomplished by return of premium include:

1. Expanding the spread of morbidity risk by encouraging healthy insureds to persist;
2. Lowering the initial cost of non-age-rated underlying coverage by providing a substantial benefit that is attractive to younger, healthier applicants who are more likely to be nonclaimants under the base coverage; and
3. Helping to eliminate the potential rates spirals due to cumulative antiselection by rewarding persisting healthy insureds.

It's essential to the pricing of return-of-premium benefits that these elements be considered.

Finally, just a few words on the future of dread disease insurance. I personally believe there will be a market for dread disease insurance for many years to come. As the December 1994 issue of *The Journal of the American Medical Association* indicated, there is a real need for these products. But in this era of increasing concern about sales practices and disclosures, I believe there will necessarily be some improvements in this area among sellers in the market. It's too early to tell what may come out of the limited benefits working group of the NAIC, but I would anticipate that, at a minimum, there will be a push to better enforce existing regulations. It seems likely to me also that companies will have to do a better job of asking about other health policies so insurance stacking does not occur.

MR. CURTISS S. SHELDON: It's a genuine pleasure to be asked to participate in this panel discussion. I'm going to shift the discussion toward the product management of a block of specified disease insurance as well as the characteristics of that type of product when it's used for a payroll deduction. I'll also get into a little futurism at the end. I really enjoyed the comments made by David and Mark. Mark did a very good job of covering the consumerist issues, and they are important issues in the cancer market. They help frame the attitude of the regulators as well as the attitude of the consumers in general.

What is your perception of cancer and specified disease policies? Are they profitable for the companies writing them? Are they a good buy for the consumer?

As to the question of the value of the coverage, we need to look more realistically at the profitability of the product with the tremendous advantage of hindsight, which we all know is 20/20. Many of the specified disease policies issued a few years ago have provided outstanding economic benefit to the consumers who purchased them. I've heard of individuals receiving benefits in the hundreds of thousands of dollars for cancer treatment. Some of these policies, obviously, have not turned out to be particularly good contracts for the insurance carrier. We'll repeat some of the things David talked about. Certain benefits were included in the policies, which were probably never imagined to be really high risk to the insurance company. They were likely intended to be additional benefits to provide more complete coverage and provide extra sales appeal. Unfortunately, the amounts of the benefit payments were often phrased in terms of actual charges, rather than indemnity amounts. In addition, many had no safeguards to limit claim payments to usual and customary charges.

The high-risk elements were these: provision of benefits which are equal to actual charges for chemotherapy, radiation, and blood services without any limit as to amount. In the jargon of the marketplace, these are typically referred to as uncapped benefits. A second

type is extended benefits, which provides payments equal to actual charges for all treatment after the insured has been hospitalized for an extended period—say 90 consecutive days. Some of the most costly claims have arisen from these two types of unlimited benefits.

Utilization of the benefits has been tremendously impacted by technological advances. Treatment techniques exist today that were not even imagined in the mid-1980s. The cost for this new technology has skyrocketed with new inventions and treatments. For example, new biotechnology drugs have been brought to the market, which cost $3,000–5,000 per treatment.

Costs for more routine procedures have dramatically escalated as well. Benefits under specified disease policies have participated in the tremendous increase in medical inflation over the past few years. The situation has created quite a dilemma for companies who have substantial blocks of business with benefits keyed to actual charges.

The situation that has developed presents the actuaries a challenge in managing the product lines on a profitable basis. It is crucial to monitor experience on an ongoing basis for each of the plans. One measure of experience is to compare actual claims to expected claims for particular benefits provided in the policy. This implies that the company has a claim system in place that will provide sufficient data to be able to do that. Expected experience should be based on the tables used to originally price a product. This type of study provides feedback for the performance, and data for pricing of future products that would provide similar benefits.

Let me show you a hypothetical example. Table 1 is not a real policy, but it might have been one that would have been issued say in 1985. Many of the benefits have turned out to be less than 100% of what was expected, but the real offenders turn out to be over 2,000% of the expected. Overall, the policy is now at 165%, assuming that we've had no rate increases in the process. It obviously is in need of a rate increase.

The second method to use to review is based on duration. You can look at the experience year by year, as in this hypothetical example (see Table 2). In the first duration, the policy had better experience than expected and then the experience started to slip. With this type of monitoring, it becomes apparent pretty early on that a rate increase needs to be addressed.

Once a problem is detected by the company, you must decide what remedy to pursue. In a number of instances, that remedy will be a rate increase.

Many of the policies are guaranteed renewable for life, with a contractual right to change premiums on a class basis, typically subject to state approval. A company may decide to seek a rate increase to return the product to the level of profitability anticipated in the original pricing, but that would be prospective only. It is unlikely that it would ever get a rate increase large enough to recoup past losses. The company should not delay in making this decision, since this adjustment can only be on a going-forward basis.

TABLE 1
HYPOTHETICAL EXAMPLE OF A POLICY ISSUED IN 1985

Benefit	Actual to Expected
Hospital Room and Board	75%
Extended Benefits	110
Inpatient Drugs	75
Radiation and Chemotherapy	2,400
Surgery	120
Anesthesia	50
Physician Fees	70
Blood Services	2,500
Experimental Treatment	140
Ambulance	200
Prosthesis	400
Skin Cancer	45
Miscellaneous Benefits	100
All Benefits Combined	165%

TABLE 2
HYPOTHETICAL EXAMPLE—REVIEW BASED ON DURATION

Year	Expected Loss Ratio	Actual Loss Ratio	Actual/Expected
1	40%	32%	80%
2	43	47	109
3	48	62	129
4	50	72	144
5	54	80	148
All Durations	50%	65%	130%

Timing may be an issue. Even though we can look at an analysis like this and it shows the need for a rate increase, some states are reluctant to approve the request until the product's overall loss ratio exceeds the ultimate expected at that state's particular required level. The amount of the increase may be an issue as well. Some states limit the amount of the increase, which can be requested. There are a number of states that won't look at a request for more than 25%. We've experienced others who, after they've reviewed the filing, will reduce the amount or not grant any at all.

Once the decision for a rate increase has been made, the next step is the preparation of the actuarial memorandum justifying the rate increase. Items included in the actuarial memorandum include: purpose and scope of the filing, reason for the increase and the effect on premiums, rate increase history, rate increase standard for that particular jurisdiction, all of your assumptions, historical experience, and current loss ratio. Then you get into the real important part—the projection of future experience. And finally, you must include a statement of the lifetime anticipated loss ratios.

Then to accompany that, we would have an actuarial certification. It would certify that the filing was in compliance with law and regulation. Anticipated loss ratios that are expected to develop and that benefits are reasonable in relation to premiums.

I would just point out to you that *Actuarial Standard of Practice (ASP) Number 8*, "Regulatory Filings for Rates and Financial Projections for Health Plans," applies to this type of filing. Once the filings are in the mail, we can sit back and wait for the approvals to be returned. Actually, what happens at that stage is preparation of the home office systems and service units to administer the rate increase. Once responses do begin to come back, the company is immediately faced with a lack of uniformity. States may approve, disapprove or modify the request. Our experience has been that it is necessary to administer different premium rates on a state-by-state basis following one or more rate increases. There will be a core group of states that may have the same rate, but then others will vary all across the lot. There's also a timing dilemma at this stage. A number of states will approve relatively quickly, but discussions will be ongoing with others over an extended period of time. A decision must be made whether to implement a partial group or delay until most states have approved.

The first stage in the implementation is to notify the policyowners and agents of the upcoming change. Various jurisdictions require different notice periods, anywhere from 30 to 90 days in advance. The process is fairly straightforward with regular billing modes. After the notice period, an updated bill or an automatic electronic funds transfer deduction can be put into effect. Under payroll deduction, the process is more involved. Efforts must be made to accommodate the payroll case. The employer must change their payroll deduction records and typically they will want to do this on a common date. They may also request a delay to a special date, such as their cafeteria plan anniversary. That way they could coordinate with other changes to their payroll deductions. It is vital to explain the necessity of the rate action to the employer and to obtain corporate support at that level.

That leads me into some payroll deduction comments. A significant portion of the specified disease policies in force have been sold through workplace marketing, and premiums are collected through payroll deduction. In the case of my company, virtually all of the policies were originally sold at the worksite and about 80% of them still pay premiums through a payroll deduction. There are a number of advantages associated with buying coverage at the workplace. The first is convenience. Consumers feel they receive lower cost through group purchasing, more complete coverage and they are less likely to be rejected for coverage. Employers use these products to give employees more choice and enhance benefits at little or no additional cost. In many cases, employees have asked their employers to make voluntary coverages available. The worksite marketplace has stamped its collective seal of approval on specified disease policies over the years. They have been successfully marketed for more than 40 years. Internal Revenue Code (IRC) Section 125, cafeteria plans, has further boosted the popularity of voluntary products. The employee can move premium payments for specified disease products to a pretax position by salary reduction within a Section 125 plan, which lowers taxes for both the employee and the employer.

The age and sex distribution of specified disease policies sold through payroll deduction is very important. They are typically sold at one premium rate for all ages and both sexes. Pricing assumes a typical age distribution. Variations from that distribution can cause

large swings in expected profitability. Typically, pricing would be at around an average age of 42. In certain groups, it may tend to be at an older age than that, and in some groups, it is at a younger age. The particular business should be underwritten to verify that employees have a favorable demographic composition, as well as make sure that there are no unusual morbidity risks. You would also want to look at employee turnover rates, which could lead to high lapse rates.

Payroll deduction business is service intensive. There are a wide variety of payroll frequencies demanding billing flexibility. Premiums may be deducted weekly, biweekly, semimonthly or monthly. In the case of teacher groups, sometimes deductions occur nine or ten times a year. Your administrative system must be able to accommodate all of those types of things. Billings may not match payroll deductions from the employer. The deduction may be for the wrong amount. You may find out that employees haven't been at work and they didn't get a paycheck. Rapid claim turnaround and fair claim adjudication are also very important, since the plans tend to be viewed in the same way as employee benefits.

Don asked us to look at the future and I think my comments echo Mark's to a certain extent. I am cautiously optimistic about specified disease for the future. We're still seeing the expansion of the market. Newer products such as heart attack and stroke coverages are coming on to the scene. Many consumers want to buy this type of policy. Consumers are becoming more knowledgeable of medical treatments and the cost associated with them. Many of them are growing older and they realize that they are vulnerable to dread diseases. They realize that medicine can help them survive longer, but that there is a tremendous cost to go along with that technology.

The Life Insurance Marketing and Research Association (LIMRA) recently released data from a survey on worksite marketing, which found that 24% of employees are interested in purchasing dread disease coverage. From a payroll deduction point of view, there are still a large number of employers who do not offer voluntary coverage to their employees. That same LIMRA study found that about two-thirds of employers with 2–2,000 employees do not offer any voluntary insurance products. The percentage for smaller employers would be even higher.

There are some challenges for the future. The competition is quite intense, particularly in the payroll deduction marketplace. The regulatory environment is a challenge, as has been mentioned several times. Required loss ratios are likely to increase, which will make it difficult for companies to provide adequate compensation to their field forces and still maintain acceptable profit margins.

MR. PATTERSON: First I'd like to thank Jeff Morris for serving as the recorder for this session, as well as thank each of the panelists for their excellent presentations. We now have time for questions.

MR. STEPHEN F. KRAYSLER: I'd like to ask Curt about the worksite payroll marketing. Why would you go in with a single rate for all when it is subject to distribution risk? Is that some legal necessity?

MR. SHELDON: No, the age part of it is not a legal necessity. Competition is the answer on the age side. Virtually every company in the marketplace is in there with uni-age rating. Of course, when we sell direct we don't do that, but on the payroll side we do.

FROM THE FLOOR: First of all, a comment on that last question. It's very much true that the competition is going to force you to a single rate situation. This is a sale that is meant to be quick and easy and agents do not want to fool around with even two or three different rates. They already must worry about probably an individual rate versus either a single parent, possibly, or a family rate. Some companies even break it further than that. That's more than enough complexity for the average agent in what is meant to be a quick and simple sale.

I did have a question really for everyone and it sort of spins off of one of Dave Arial's comments, which is how the future will perhaps become simpler rather than more complex. There are two product designs that I have seen recently, that I think tend to take that approach, and I'd just be interested in your comments on them. One of them we have affectionately dubbed the "sweepstakes policy." If you get cancer, we pay you $100,000 or we pay you $200,000. This is one that several other companies have. The other one is a policy that does not really address the payments towards specific medical things. If you are hospitalized, you get so much a day for child care, you get so much a day for telephone calls. What it basically boils down to is just a hospital indemnity benefit that has been fractionated into various things. But even the rest of the benefits that are in the policy tend to have less to do with the medical things themselves. They are really related to the ancillary cost, and as a result, there tend to be fewer of them. They tend to be much more easily understood and are not quite as arcane sounding as, "We'll pay you for an autologous bone marrow transplant." Some of these benefits are getting so complicated that if the insured is not a physician himself, he really doesn't have the slightest idea of what the benefit is for. I'd be interested in your comments on both of those.

MR. SHAW: In regard to the sweepstakes policy you described, I think there are a couple of concerns. First, what is the need that you are trying to meet? And, as I indicated in my presentation, I think that a number of the companies have positioned their benefits, even though they are triggered by specific medical events, to pay out-of-pocket costs. The more medical events that you have, the more out-of-pocket costs presumably that you have. What happens with a single benefit product is that regardless of how many medical events you have and regardless of what your out-of-pocket costs are, you end up with a flat benefit. Maybe there is some part of the market that wants that, maybe not.

I do think that simplicity is something that, because of the agent issues that David mentioned, is likely to happen. I think that will also be driven by disclosures. I think that there is more push for more disclosure on each benefit. The bottom line is that if you're going to have to say a number of things that you haven't said in the past and you have the same amount of time to do your presentations, you're going to need to chop the benefits down so that you can focus on the benefits that really are important.

In regard to the design where they chop the hospital confinement into a number of benefits, I view that personally as more of a marketing ploy than anything else. I am aware that there are a couple of states that wouldn't buy that. California is one that springs to mind, that they would make you reconsolidate all those things and call them a

hospital confinement benefit, as opposed to allowing you to chop it into pieces like that, but I'd be interested in hearing the other comments.

MR. ARIAL: I believe that the future is much more simple. Our product, to take an example, is very difficult even for the actuaries to understand, so I don't think the customers are really able to understand it. Unless you're an oncologist, it's very complex. I think that in keeping with the times, where the government, the employers, and the insurers are paying much less, it's going to be put on a basis of — if you can be fixed, we'll pay some. Then that leaves it up to the individual to provide for the remainder. I do think that the high initial diagnosis, or diagnosis-type-oriented benefit, is very similar to a lump-sum-disability-type payment. I think there is a real future there. Now the regulatory challenges could be very large. Regulators typically do not like innovation, so I think there's going to be some real challenges in that area, but I think that's where the future is.

MR. SHELDON: As to Carl's question, I think I would just echo the statements by David and Mark. Go back to age just a minute. We are making a little progress. We have a couple of other types of payroll products that are age rated like disability income and hospital-income-type products. I think we may see that come in the dread disease area as well.

FROM THE FLOOR: Do you sell either of those two kinds of policies?

MR. SHELDON: We do not sell either kind.

MR. SHAW: We currently do not sell the single benefit or the fractionalized hospital confinement, either.

MR. ARIAL: We don't sell either one, but we're working on one of them.

MR. ALAN W. FINKELSTEIN: We're beginning to get a number of requests for quotes on this lump-sum benefit, often referred to as a first-occurrence of internal cancer. Because I've been asked to look at various forms of cancer products, I have had an opportunity to go back and talk to Keith Sloan, who was very active in the pricing of these products back in the mid-1980s. He is a consulting actuary who was the co-chair of the NAIC task force on the cancer claim costs. He is of the opinion that the tables are vastly out of date at this time, mainly due to increased incidence of cancer, new diagnostic techniques and changes in medical practice. My question for the panel is, do you know of any efforts to try to get a task force to put together a new set of claim costs? Might I suggest that one be organized?

MR. SHELDON: It's a good suggestion. I'm not aware of any effort. We price almost exclusively from internal experience.

MR. JOHN R. BUSS: I'm aware of several independent marketing organizations to, more or less, either have a field force in place with an idea or perhaps a product itself, and go hunting for a company to carry that product. Do any of your companies work with these kind of organizations, and if so, how do you find the differences in experience, and so on, from a more traditional marketing organization such as an agency or a brokerage?

MR. SHELDON: I guess my company does not currently have a relationship with such an organization. We have in the past designed special products for marketing organizations. I'm not sure it's quite the same because they were still a general agency with a group of agents under them.

MR. SHAW: We do affiliate with some brokerage agencies in terms of distributing our products, mainly in the worksite marketing area, because there are organizations that control worksite groups. I'd say in general the issues involved are, one, How do you compensate those groups versus how do you compensate your own field force, and two, How do you avoid channel conflict? That is not managing to infuriate your field force while still being able to write the business. There are also issues of service and so forth, but I think those are the big issues for us.

MR. ARIAL: We do both career and brokerage type business, and as far as I know, our career experience is somewhat better than brokerage, but as far as independent marketing, it's not something that we do.