RECORD, Volume 22, No. 2*

Colorado Springs Meeting
June 26-28, 1996

Session 43PD
Hot Products—Individual Disability Insurance

Track: Health
Key words: Disability Insurance

Moderator: DAVID E. SCARLETT
Panelists: CHARLES N. BIETER
ROBERT G. MEILANDER
BRUCE A. RICHARDS
Recorder: DAVID E. SCARLETT

Summary: The disability insurance (DI) industry is undergoing a product philosophy and design revolution. Representatives from DI companies discuss their philosophies, new products, acceptance in the marketplace, and future plans.

Mr. Bruce A. Richards: What I'm going to do is provide some background information from the 1980–90s, and talk about the risk factors as I currently see them. Finally, I'm going to highlight what we're considering doing at Paul Revere. It's a well-known fact that we've been looking at changing our DI product for awhile. We're just concluding the discussions on what we're going to do, so I'm not going to disclose what that is but I'll certainly give some good hints.

Before beginning, I have a few items I'd like to highlight. This is a period of change at Paul Revere. As most of you should be aware, we're merging with Provident. That transaction should be complete sometime in September 1996. I've been the chief actuary at Paul Revere since October 1995, and that includes responsibility for our group line, life products, and individual disability income (IDI) lines. This incorporates pricing, financial reporting, valuation forecasting, product development, asset/liability management, and a few other miscellaneous things. The other thing I think that's noteworthy for Paul Revere is, although we're an IDI company, my primary background is really group insurance. So even that's a change for Paul Revere.

In addition, Paul Revere is currently a noncancellable IDI carrier. That means we have no guarantee renewable product at this time, although we're certainly going to have one in the near future. The other thing is, from a pure perspective, I have viewed the IDI as being a boutique market in the last few years. That means it's a small market and we sell to a very limited audience. With that I'd like to get started on some comments about the 1980–90s.

Looking at the 1980s will set the stage for why we're in the position we're in. You have to remember that my perspective of IDI really begins in 1995, and my reviews tend to be rather critical, harsh, and somewhat sarcastic and cynical.

The early 1980s were characterized as being very profitable, and many things were going on. The investment results were particularly strong. If you recall, inflation and interest rates were quite high and that investment criterion was providing some hefty returns. At that time, physicians viewed it, if you can believe it, as a real good risk. Paul Revere couldn't write enough IDI so we did some things that in retrospect look strange now. The environment was really competitive, and it was a period when product liberalizations and underwriting liberalizations were very common. In the 1980s, the focus for Paul Revere was really more on market share than it was on bottomline profitability. We were convinced that we wanted to be number one in market share. We would watch Provident move ahead and then we'd move back ahead. That was one of the underlying themes for that period of time. In the mid- and late-1980s, experience began to deteriorate. Companies began changing their product rates and underwriting practices, and we knew that our returns in the business that we were writing probably weren't as strong as we'd like them to be. In fact, it would be fair to say, we knew the returns were anywhere from a small negative loss to a small positive return. It certainly wasn't anything large.

As we moved into the 1990s, the poor claim experience began to accelerate. The real cause, I'd say, was that the contracts written during the period were very liberal. If I focus on some of the internal underwriting that was incredibly liberal too. Further compounding the 1990s scenario was a shift in the interest rate environment. Yesterday, one of the people from my staff did a session on accident liability management. We actually weren't well matched in the 1990s at Paul Revere, and we inadvertently took on some financial risk.

The third thing that happened in the 1990s was the implementation of the deferred acquisition cost tax. That further complicated our lives. There's been a focus on capital ratings, and it's fair to say that we've spent much time on capital ratings at Paul Revere.

The other thing is that there has certainly been changes in the risk-based capital formulas. These changes have not been liberalizations but have been requiring more and more capital.

Finally, there will be a common theme of DI industry consolidation. More and more companies are getting out because experience was poor. That lead to Paul Revere's national account type relationships. And again, attributable to the poor experience, we're implementing changes in pricing, underwriting, and compensation. In general, the 1990s are characterized by a period of declining industry sales, although Paul Revere sales tended to be rather strong and were increasing during the period.

Paul Revere took a dramatic increase in claims in 1994. The drivers for that experience were this particular block of physician business written in 1985–89, California and Florida business written in 1985–89, and five national physician specialties. In addition, we did some more analysis and found it wasn't really the core DI contract itself that was the problem; it was really the associated riders. We were selling loaded policies. Every single rider available was being put on that lot of the business. The business that wasn't loaded with riders was fundamentally performing well. The other part that became apparent is the benefit levels—the high indemnities that we were selling certainly were not profitable. There's a problem between high indemnities and overinsurance. I think what you'll hear is that overinsurance is a common theme for one of the things that's wrong.

If I take 1994–95 and go down those same categories, it won't be too surprising that 1985–89 business for Paul Revere in general got worse in 1995 than it was in 1994. In the physician specialties, those five things certainly were not performing well. For physicians, in general, nonfive specialties were deteriorating also. There was a common theme in most of the physician business; it tends to be overinsured, poorly underwritten, and the fundamental change in the managed disability was cutting physicians' incomes. One of the assumptions in the late 1980s was that incomes, particularly for physicians, would never go down. So there's a fundamental flaw in one of the contracts.

Our first quarter of 1996 was worse than our fourth quarter of 1995. That was principally centered in some business in California and Florida and there were some high indemnity problems. For the five specialties, it was continuously increasing through 1994 through the third quarter of 1995 (Chart 1). It went down a little bit from 1994; however, if I was to place the first quarter of 1996 on there, it would increase again. The nonfive specialties have been continuously increasing in terms of loss ratio since 1992. Again, if I add 1996, that line would increase. That's a mix of what you see at Paul Revere right now, in early 1996.

CHART 1
FIVE-SPECIALTY PHYSICIAN

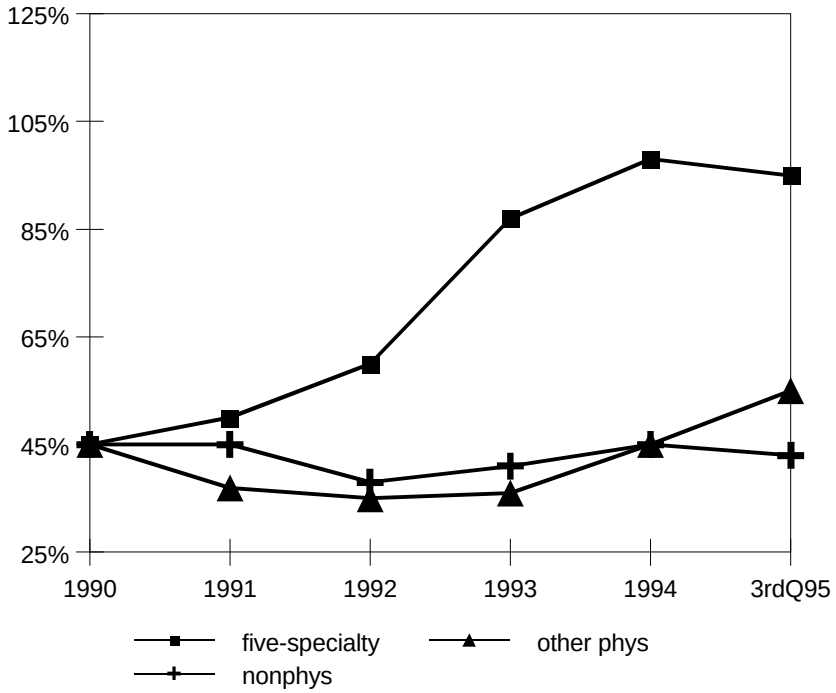
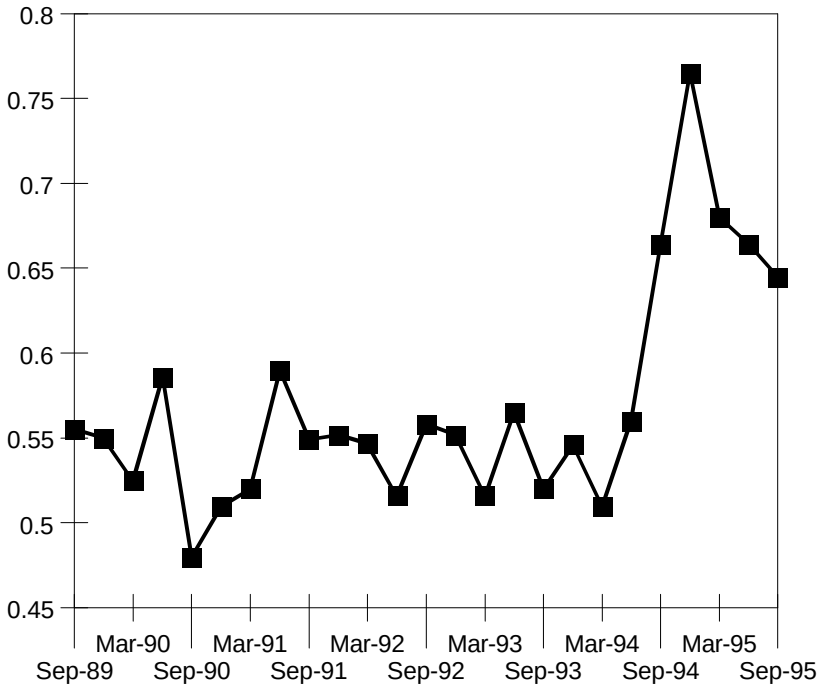


CHART 2
QUARTERLY NET BENEFIT RATIOS



One of the things we do at Paul Revere is track experience by net benefit ratio (NBR). NBR is basically GAAP incurred claims where you take away investment income and divide by premium. We tend to use this measure because it allows you to see trends better than with gross loss ratio. If you look at Chart 2 from September 1989 to March 1994 it is fairly flat, meaning that our loss ratio experience is behaving well. If you look from March 1994 through September 1995 you'll see it is elevated, and it's clearly highlighting the problems with physicians, California, Florida, and high indemnities.

I'm going to talk about a few of the risk factors we see at Paul Revere. The first category of risk factors includes the ones that are external in nature, and I call most of them economic. It's well known that inflation or lack of inflation has a direct impact on recovery rates. The second thing that has occurred during this period is there has been a recession, which has impacted those with higher income for the first time. It wasn't necessarily a bluecollar recession, it was a white collar recession. What that really meant was there was a lack of high-paying jobs for people to find, and that has certainly affected experience. The third thing that has been going on at this time, and is still an economic risk factor, is health care reform.

Health care reform for a lot of business we insure has served to increase incident rates. And that was further driven by, as I mentioned earlier, some overinsurance and some very poor underwriting. There are some other things occurring that would be considered economic factors. The bottom line is most of the economic factors are things we do not control directly. When you're looking at future product development, you want to manage what you can and reduce the risk of the things that you can't totally control.

The last thing I'll mention is there are other unpredictable factors. One of those is regional economies. In my role, I mentioned I have responsibility for group insurance and individual insurance. I can tell you for many of the regional things we're seeing, I can cite their group phenomenon. They are individual things so there's a great correlation between some of our group experience and some of our individual disability experience.

There's also a great risk for societal changes. It's well known that the Americans with Disabilities Act has impact by way of the federal government. Things have changed in the way people perceive people with disabilities. It's more acceptable to have a disability. In certain states, it's even more acceptable to have something like a mental or nervous claim. In addition, society continues to have a suit mentality, so when developing products you need to incorporate those type of thoughts. You need to sit there and say, if I were going to file a claim what would I

be doing? What we're trying to do is incorporate some of that thought process at Paul Revere. During the period there has also been a great change in motivation ethics. They were the most desirable group back in the early 1980s. Insurers were rushing to write many physicians at this point in time.

Society's acceptance of being disabled has an impact on how many people will file claims and what type of claims they'll file. Finally, the new types of disabilities, the serious versus the nonserious, such as tissue, chronic fatigue, and environmental allergies, require us to think about how we're going to adjudicate claims and price and underwrite a product. There's also diagnosis versus disability, which is adjudicating a claim rather than accepting information conveyed by a physician. I also point out that some regulatory issues can go both ways. From an industry standpoint we need to be more proactive and generate change that's necessary.

Finally, on the risk issues if you look at the business we wrote in the 1980s, you see what happened was self-inflicted wounds. The contracts that Paul Revere wrote at that time certainly had insufficient or almost no return-to-work incentives. They were characterized by overinsurance and excessive liberal benefits and underwriting policies. At Paul Revere, we had 20 claims that have over $60 million in reserve liability associated with them. Some of the people on my staff are going through them, and they have some fundamental characteristics. In that period, market share and competition were intense, and there wasn't enough information to tell you not to accept some of those risks. But because we thought the physician risk was one of the best things around, I'll say in retrospect that we took some risk that a sane person wouldn't even look at today. There are some real obvious things that went wrong, and just tightening some of the underwriting provisions has gone a long way to avoiding some of the poor experience that could emerge.

The last company cost or self-inflicted wound we had at Paul Revere was focusing on market share. We were focusing more on top-line performance (which is sales) than bottom line performance which is profits. To a certain extent that drove the industry in that direction.

About 30 years ago, Paul Revere was a blue collar-type company. In the past 20 years, we've switched to what I call the boutique market geared to highly compensated professionals. We're going to move that strategy. It's a shift to the middle market where probably the greatest population is. I'll talk to you about highly compensated workers versus blue-collar workers. There certainly are different benefits, different contracts, and different characteristics that you want to address in a product. Our goal in moving to the middle market is to spread the risk by having a broader base of insureds. We want to take greater advantage of the fact that people are just coming into their prime earnings capacity. Part of that strategy

will be the focus on work-side marketing. We certainly have to acquire further product revision and some underwriting changes in order to be successful in that target market.

What's on the horizon at Paul Revere? Even before the merger with Provident, we were doing some things for our distribution system. We decided we wanted to be a disability company. By that I mean we wanted to give the customer the right solution, whether that be group insurance, individual insurance, or some combination of the two. Earlier this year, we combined our groups in brokerage offices under single management and location. That was a major step for Paul Revere. I think one of the other things that's important for me to stress is we have seven regional managers. Three of them have group insurance background, which was all they had done, and the other four were brokerage people. So we intentionally made the focus on group insurance as we did on individual disability.

I point out under the system there are still group and brokerage representatives. So there is focus on a particular segment, but the real focus is to try to get at the customer need. There's an issue that we had of cross compensation, and in our previous alignment, if one of our brokerage people referred a case to the group insurance people, he or she got nothing for it, so there was really no incentive to do that. We've now created a cross-compensation method that gives an incentive to those people to do that. As I mentioned before, our focus is now on solving customer need versus peddling a product.

I'd also add there are a couple of other things that we're doing on the distribution side. We're implementing a producer selection program. We've had one for awhile, and we're going to beef it up. There's tremendous variance in our results by producer. I've had the opportunity to look at some of them, and there are producers where we have five or six contracts outstanding on them and three or four more are in claims. That will not be tolerated in the future. We're going to do some weeding. The other thing I mentioned under distribution is we're going to look at alternate distribution, which includes not using our brokerage people. There are more ways to market through banks. We are looking at the way we do business, and certainly it's going to change.

One of the other things is Paul Revere has been a top line company. Because we've had a tremendous focus on sales, we had a little problem in that our sales people were compensated based on production, and home office management was compensated based on profitability. So there wasn't a complete alignment of goals. One of the things we're working on is aligning those goals. That's an important thing for us and makes life a lot simpler when everybody is focused on the same issues. We intend to further expand our national accounts if possible, and if you're

not really aware what national accounts are, we're basically using sales agents of other companies to distribute our product.

Finally, on the compensation front, I should make you aware that there will be a material change in how we pay our salespeople and producers. In the world of product enhancements and revisions, our real goal is to make enhancements, to make earnings dreams more predictable and less volatile. Some people have asked me, what does that mean? It means that if we look at the contract pieces that we know we've been abused on, we're certainly going to greatly reduce those provisions, their availability, and in some instances we might discontinue them. Some of the benefits like mental and nervous, as any other illness, are going to come under some severe scrutiny.

We will also in this line once again take a closer look at California and Florida. California and Florida have caused us an inordinate amount of pain. We're going to carefully look at the products we're selling there and, if necessary, make them more restrictive. The other thing that goes along with that in our new product enhancement is we're seriously looking at area rating beyond Florida and California. We have a three-tier rate structure today, it's Florida, California, and other. If you look at experience in the Connor Report, and I can look at my own internal experience, there's much more variation in just California and Florida.

For the first time Paul Revere actually has a strategy to shift the mix of our business away from physicians. We used to have a passive strategy that said, write whatever you can but don't write too much of something. We actually have explicit targets on physician production for 1996. Our people have hit them, and are actually coming lower than our targets. We're very happy about that. We've also created a focus for our IDI marketing as multilife business. As a matter of fact, we prefer to avoid the individual one-on-one sale, and our bidding on the individual one-on-one sale is much worse than the multilife sales. And that is certainly one of our biggest strategies.

I'll give you a little play on words here, it says noncancellable but with flexible premiums. It's certainly fair to say we're going to have a flexible premium product. I don't really know whether you call that noncancellable or guaranteed renewable. But it's safe to say that Paul Revere, in its quiver, has developed a flexible premium product. One of the other things I look at in my corporate-type role is what value do we convey to the consumer? When you look at all the compensation we pay and all the expenses, there's not a great deal of value left for the consumer. I think that there has to be something done on an industry-wide basis because more of the dollar needs to go to the claimant. That sounds silly when I show you all the 1989 premium ends up in the hands of the claimant.

A couple of other things that we're looking at are disability management services. We, as a company, believe we can market that. We have a viable group operation that can do it. We also believe that we can do that from an individual disability aspect too. Also, in our product development efforts, we look at combination product focus. Selling DI and long-term-care DI and annuities, DI and life are certainly on the drawing board, and we believe that has significant value.

On the drawing board at Paul Revere is the further combined or group and individual operations. And that's really home office type operations. I've already mentioned that we've combined the field offices quite well, but there's a big push to make sure that we're looking at everything appropriately. We have some knowledge on the individual side that greatly benefits our group people and vice versa. We're also going to put some additional claim resources on managed risk. We believe that applying more resources will generate a better return. And, as most people know, Paul Revere does have a proactive litigation philosophy. We do actually initiate many revisions, and so that will continue to be one of our philosophies.

Looking ahead, I guess there are two things that I would mention. I'd say, one, I believe our new product portfolio will have a substantial deliberalization of benefits and underwriting provisions, and two, the second biggest and probably the most important thing for us at Paul Revere is we have a merger pending with Provident. There's a lot of work and coordination to bring those two companies together. By looking far enough along, what eventually will happen is there will be one philosophy, one set of products, one set of underwriting, and one set of resources to address all these issues. Summing that up, I think it's fair to say that I perceive there's going to be a lot of change which is necessary and not too far away.

Mr. David E. Scarlett: Many good thoughts there for us. I'd like now to introduce Nick Bieter. Nick is assistant vice president at Provident Life and Accident. In that position, he's responsible for individual DI product development and pricing.

Mr. Charles N. Bieter: This year, 1996, has been a memorable year so far. Bruce has talked about some things that will make it even more memorable. We might think about the Olympics or the November elections. Many things will make 1996 a memorable year, but for just a few minutes I'd like you to think about 1996 as a different sort of a milestone year. In fact, it's the ten-year anniversary of the first clear evidence of claim problems on individual DI. I know that in some companies you saw problems before that time, and many companies saw problems after that time, but for many companies, and Provident was certainly one of them, the first clear evidence of the claim problems began with 1985 dates of disability. Those claims were reported and were very evident about ten years ago in June 1986.

To track the effectiveness of new business to see how we are doing since 1986, I use the ratio of actual incurred claims to an old pricing claim cost table that Provident developed in the early 1970s. On business within the first two policy years, the 1985 date of disability claims was the first major change. It was an abrupt jump from the experience that we had prior to that time. In 1986–87, we had bad years. By 1988, there was some improvement, and we began a gradual pattern of improvement until we reached 1993. By 1993, new business claims experience was actually back to the level that we had enjoyed prior to 1985. I consider that to be an exceptionally good result considering how the world has changed in the last ten years.

Although new business today is performing fairly well, I believe some significant change must happen to the products before we'll feel comfortable with how these products will perform into what is, frankly, an unknown future for disability income. Ten years of claims experience is a long time, and during most of those years we have talked in meetings like this about what the claims problems are. Short elimination periods, California, and physicians have been mentioned, so I'm not going to go into those again. Most of you can give me that list of claims problems every bit as well as I can. What have we really learned in ten years? One thing that I learned was that the actuaries that I worked with years ago were wrong about at least one thing. They told me that working on DI products would be a combination of actuarial science and art. In fact, DI is a combination of actuarial science and chemistry. Chemistry helps explain experience and define new products much better than art.

In DI chemistry you have some basic elements just like in regular chemistry. The DI elements are things like the definition of disability, payment functions, rate guarantees, and financial and medical underwriting. Premium integrity is also very important. Mix some of these elements together, and you can create some dangerous compounds. Some of these compounds are stable at some temperatures and they're unstable if the heat gets turned up. In DI chemistry, the temperature or the heat that I was talking about are things like secular trend, economics, society's acceptance of disability, and acceptance of mental conditions. It includes legal and regulatory issues, and new diseases like AIDS or the popular disease of the day. It includes medical advances, interest, lapse rates, and all the other items that you know about. Of particular interest in the level of heat, I believe, is the economics of the occupations that we have issued to. I'm talking about medical economics.

When we talk about experience on DI coverage, and how to design new products, some people in our industry have stressed one of these elements of DI chemistry. They've talked about noncancellable or own occupation, and they've tried to explain the results and their new product philosophy based on that one element. I

believe that all of these DI elements are stable, at least by themselves. The problem is the combination of the elements and the amount of heat that gets applied to these combinations. When we look at our experience data, we try to do that in light of the level of heat that has been applied to the particular combination. For example, the medical profession has had a very high level of heat and everybody understands that. So when we compare claims on mortality deductions to claims on another occupation, we have to do that in light of the level of heat that has been applied before we can make a good prediction about how coverage will perform out into the future. For example, what would the claims experience be on lawyers in recent years if they had gone through the same sort of economic and social pressures that the physicians have undergone?

I don't want to sound pessimistic about DI. Actually I'm optimistic about DI. I'm optimistic about how the in-force business will improve in the future, and I'm particularly optimistic about how new products will perform in the future. But I am concerned that we may misinterpret claims experience by concluding that some of the combinations of coverage that we are selling now are necessarily stable compounds. It's possible that they're stable only because the heat hasn't been turned up yet.

I know that today's subject is new products, but I think the way to describe new products depends on your view of the past problems and your view of what the future will be like or your degree of uncertainty about the future. I think the question is, how much heat should your current DI product be designed to withstand? From my point of view, the world in which we sell DI will continue to change at a rapid pace, and the products we sell will have to be flexible in order to survive. To evaluate the acceptable level of risk for a new product, I think it's helpful to have some risk guidelines, which I've called product principles.

I would suggest these product principles. First, DI coverage should protect the customer from economic loss because of disability. There should be a strong link between the benefit and the extent of the loss. There should be no windfalls. People should not be better off financially when disabled than they were before becoming disabled. Second, the customer has a responsibility to help mitigate a disability loss to a reasonable degree. If that language sounds familiar, it might be that you've seen it in some homeowner's policy or an automobile policy. Let me explain that these principles are mine. This is not an official company position. Even if you accept these principles as good guidelines to product development, different people will come to different conclusions about how to apply the principles to a new product. I know this first hand because I spent months on a product review team at Provident, which completely redesigned the Provident individual DI product. I do not believe that there is one best product solution for all

companies. One product will not fit all circumstances. But Provident's new Cornerstone product does fit the company's circumstances, and it does adhere to the product principles that I mentioned.

At Provident we used policyholder focus groups, broker focus groups, and extensive broker interviews to help us better understand our customers and design the Cornerstone product. We found that most customers expect to be paid according to his or her loss due to disability.

Customers want the insurance company to help them get back to work. The agents seem to agree with these basic disability needs, but the rapid changes within the DI industry have made their jobs very difficult.

The Cornerstone policy is built around a theme of providing extra benefits to help claimants get back to work and providing long-term benefits that are as high as practical for those people who cannot work. Cornerstone comes in both noncancellable and guaranteed renewable versions. Our marketing people will probably talk only about the noncancellable type because research shows that agents and insureds value the rate guarantee more than what I would consider to be its natural value in pricing. Perhaps this is because we have done a very good job of teaching them to value noncancellable highly. In fact, a few years ago, our business went by the tag "noncan." In recent years some people have said that Provident was out of the noncancellable business, and others said that we were out of the own occupation business. But the truth is, Provident stopped selling the noncancellable/own occupation combination. We have sold noncancellable loss-of-earnings coverage, and we have sold guaranteed renewable own occupation coverage. The Cornerstone product has elements of both the own occupation and the loss-of-earnings language. It is a hybrid policy.

I'd like to tell you about some of the major elements of the Cornerstone policy. First is the definition of disability. It is essentially an own occupation definition; that is there's a loss of time or duties in the insured's occupation because of injury or sickness. There is a requirement of a 20% loss of earnings. I see no conflict between the own occupation definition and the basic principles that I mentioned before, except that the 20% loss of earnings is required to avoid own occupation type claims that can have little or no real loss. Cornerstone is different than pure own occupation coverage, where there can be a fairly weak relationship between the actual loss and the benefit payments.

Disability payments on Cornerstone are based on loss of earnings, and in this respect Cornerstone is an income replacement contract. We chose it because it makes a strong link between the financial loss and the benefit payment. Some

people speak of a loss of income policy as though it's foreign to the recent DI culture. However, loss of earnings formulas have been a common part of the proportionate benefits under DI contracts for many years now.

Provident chose not to use a pure own occupation type of payment because those benefits do not necessarily link the benefit to the claimant's loss. We could have chosen own occupation not working as the payment definition. That approach pays benefits like pure own occupation, but requires that the insured avoid gainful work. But this approach violates the principle that the client should help to mitigate the loss. Of course, there are some residual and partial benefit riders that can accomplish somewhat the same things as Cornerstone, but my concern with the own occupation not working type policy is that the insured's monthly indemnity may become out of line with earnings after the time of issue.

You can't really separate product language from underwriting, particularly financial underwriting, and own occupation not working contracts rely on issue and participation tables and income verification to accomplish the link between benefit and loss. However, economic circumstances can change rapidly, and we've seen much of that in recent years. I think we'll see much more change in the future. It's important to keep as much economic link as possible. Realistically, even a loss of earnings type policy can get out of sync with economic realities years after issue, but at least, in theory, the issue limits on loss of earnings coverage can be higher than limits on own occupation not working policies because of the work requirement.

Speaking of the work requirement, *reasonable occupation* is a Cornerstone concept used to define when an insured can be expected to work, i.e., helping to mitigate the loss. Reasonable occupation is based on three things: (1) the medical restrictions caused by the disability, (2) the insured's education, training, and experience, and (3) one that can be expected to produce at least 50% of the income the claimant had before disability. By the way, a $100,000 job is always considered to be a reasonable occupation.

One criticism of the Cornerstone product is that agents have a hard time explaining reasonable occupation. But have you ever tried to explain the own occupation language about substantial and material duties? I know we're all reasonably comfortable with that language; it has been around a long time, and we probably all say that we know an own occupation claim when we see one. But, in my opinion, reasonable occupation is easier to explain than substantial and material duties.

A valid criticism of some loss-of-earnings policies is that the insured is expected to work at a new occupation almost immediately after he or she is able to do so.

Cornerstone has a built-in delay on the work requirement to give the insured time to plan and to find a new job. There is no work requirement for the first 24 months after disability, or the first six months after the claimant is first able to work at a reasonable occupation.

My marketing friends would yell at me for using the term *work requirement* because they know that work is never required to get Cornerstone benefits. After the delay period that I mentioned a minute ago, insureds who can work at a reasonable occupation, but who are not working, are treated as though they are working. Cornerstone pays a maximum of 50% of the benefit in these circumstances, and if an insured is unable to earn at least 50% of what he or she made prior to disability, there is no work requirement at all.

A recovery benefit encourages claimants to return to work full time in their own occupation by paying proportionate benefits for up to 12 months after he or she is able to work full time. The return-to-work benefit in Cornerstone encourages those who cannot work at their own occupation to begin to work in another occupation as soon as possible. It pays an extra benefit for up to 12 months after the claimant is first able to work. The extra benefit comes from paying the difference between current earnings and indexed predisability earnings. As you can see, the contract emphasizes those benefits that help the insured get back to work. Rehabilitation is also stressed, but in this product it is optional on the part of the insured.

Catastrophic benefits in Cornerstone are similar to what Provident used to call presumptive benefits, that is, loss of sight, hearing, speech, or use of limbs. In the Cornerstone concept, catastrophic claims will be paid at 150% of the regular monthly benefit. That may sound aggressive, but it's intended to help those who are the most severely disabled. Mental, nervous, drug, and alcohol claims are generally limited to two years, although we do allow list billed groups to have a choice of full mental, nervous, drug, and alcohol coverage. Unlike our old loss-of-earnings policy, Social Security benefits are not counted as income to the claimant. Our marketing research found that counting Social Security as income, and therefore reducing the benefit, was viewed as unfair. The actuaries quickly explained that this was taken into account in pricing, but the marketing research shows that they didn't respond very well to that answer. Perhaps they don't trust actuaries. There is a relation-of-earnings clause in Cornerstone that holds benefits to 100% of predisability earnings. But you have to remember that a 100% replacement ratio is gross overinsurance by itself.

Of course, there are other elements to the Cornerstone product including revised issue and participation limits, revised occupation classes reflecting our current experience, and restructured premiums designed to eliminate as many subsidies as

possible. We often underestimate the real values of some of these peripheral issues. In my opinion, improvements in financial underwriting, including changes in issue and participation tables, were very long overdue. And I'm not sure that we've seen the last of the changes towards the more conservative financial underwriting.

Returning to that DI chemistry theme again, I think that there are many ways to combine the elements of a DI policy and produce what is an attractive but stable combination, one that can withstand heat. The Cornerstone product should at least conform to the DI principles that I mentioned. Those included protection from financial loss because of disability and the concept that the customer has a responsibility to help mitigate that loss. I do expect Cornerstone to change in the future. There are many ways to combine these DI chemistry elements. We probably don't have the best combination yet.

There are several subjects that I think should be addressed in a new Cornerstone product for the future. These include, first, an improved definition of reasonable occupation, one that is as fair as possible, but still effective in claims management. Second, we need premium guarantees that leave room for increases under some circumstances. I believe I've heard that somewhere else. Third, a good approach to lifetime benefits when lifetime benefits were first invented made good sense for people who were disabled at young ages, but we've had horrible experience because we did not design lifetime benefits very well in recent years. And finally, issue and participation limits need continuing adjustments. We need to look at issue and participation limits as they relate to taxable and tax-free status.

Mr. Scarlett: I'd now like to introduce Bob Meilander. Bob used to be in charge of product development and pricing for IDI at Northwestern Mutual. He's now vice president and corporate actuary at Northwestern Mutual, and is responsible for reserve testing, cash-flow testing, valuation, corporate modeling, risk management, and actuarial aspects of field compensation.

Mr. Robert G. Meilander: Throughout my career, I've heard many people stand up in front of a crowd, pound the table and say, this is what we need to do. I want to assure you that I have resisted the urge to do that throughout my career until now. And the reason for that is, as Dave eluded to earlier, this may be my last chance to give one of these speeches. For the first time in 23 years, I find myself doing something that isn't disability insurance and that's kind of strange. I'm a corporate actuary now, so what I'd like to talk about is DI product development from a corporate actuary's viewpoint. What I intend to cover are some comments on risk management, and then I'll talk a little bit about the DI product and how it works. Then I'll talk a little bit about what's needed for real change. I'd like to point out that these ideas are my own and not necessarily Northwestern Mutual's ideas. I

don't have to make these changes anymore; I just have to worry about them. So let's get on with it.

Risk management is new to me, so I'm no expert on the subject. It's something I never thought much about when I was on the product side. Since I'm on the corporate side now, I think about little else. Risk management is identifying and finding ways to deal with risk. A central issue to understanding risk management is the difference between expectation and standard deviation. The risk is in the standard deviation. We probably all heard the story about the actuary who drowned in a river that had an average depth of six inches, and it wasn't the expectation of six inches that killed him; it was the standard deviation of 20 feet. Risk management is about minimizing the risk of a shock to company surplus. It is not the same as charging for surplus. We charge for risk, but charging for it doesn't make it go away. Risk management is about minimizing risk.

There are a number of ways to minimize risk. You can spread it. Insurance companies basically are in the business of spreading risk, not taking it. We spread it by insuring lots of people and by diversification of markets. I think Bruce alluded to that earlier. We can spread it by insuring a number of different contingencies. That's something I think casualty companies try to do, but it's not an easy thing for a life company. We can reinsure it. Individuals buy insurance to reduce risk and so do insurance companies. We can hedge it using financial instruments. For example, you can do an interest rate swap to cover minimum rate guarantees on annuities. You can product design it out. Some provisions on a policy reduce variation and therefore reduce risk. An odd example of that is the own occupation benefit. By putting an own occupation benefit in your product, you actually reduce risk because there's no probability of recovery.

To summarize, risk management is not only about charging for risk; it's about minimizing or eliminating it. There are a number of ways to do that.

Now I'd like to turn to the problems with the DI product today. I think I can cover this quickly because there has been a lot of time spent on it. I don't need to review the history; you all know it. It has happened to everybody, and it reminds me of a man who emerged from a meeting and said "There's togetherness in there; everybody is reasonably unhappy." I suspect there's togetherness here too.

The bad experience of the late 1980s lead to something that Northwestern called the bottom line team. We looked at everything—all aspects of profitability including expenses, investment earnings, and morbidity. We quickly settled on morbidity as the cause of the problem. It doesn't take a rocket scientist to figure that out. After considerable analysis, the discoveries of the group were that it was

too profitable to be on claim, it was too easy to collect benefits, it was too acceptable to be on claim, the company was taking on too much risk, and there were some pricing mismatches. I think you've heard all of these things from both Nick and Bruce at least at one point or another.

The only solutions that we worked on in our loss-of-earnings contract design was it's too profitable. We reduced replacement ratios through product design. It's too easy to collect benefits. We put limitations on weak claims such as mental and nervous claims. It's too acceptable to be on claim. We didn't find any good answers for that one, so if anybody has any good ideas, I'd like to hear them. There's too much risk. Pricing guarantees were reduced by going to guaranteed renewable insurance. And the mismatch was improved by changing the price to better match cost and risk.

So the current product status in the disability area from a risk management viewpoint is that we have a much improved situation in current products, especially the loss-of-earnings products. However, I feel like we may have missed the boat a little bit in two areas, and those are the areas of price guarantees and replacement ratios. So those are the main things that I want to talk about from here on.

Let's look first at rate guarantees. The insurance principle is spreading risk. For example, the financial risk of a catastrophe to an individual is spread to many individuals by an insurance company. As long as the insurance company insures lots of people, the result for the insurer is fairly predictable. (That's the law of large numbers and we all learned about that in an earlier life.) But even that leaves a risk for the insurer: the risk that the expected level of claims, the average, will change. That's a small risk for mortality, as I'm going to show in a moment, but a huge risk for DI.

Mortality ratios, expressed as a percentage of what they were in the early 1980s, have been going down just a little bit, and down is good. The fact that they haven't been changing much is also good. On the other hand, morbidity costs, measured by claim ratios for the nine top companies in the survey done by Mark Seliber, have increased dramatically. By 1995, claim ratios were 210% of what they were in the 1980–84 period. The real situation is probably worse because claim ratios are a function of premiums and companies have been increasing premiums significantly over the past few years. If you looked at the situation in terms of claim cost, you'd probably see an even bigger increase.

So the risk of deterioration in morbidity with no ability to adjust pricing is real. It's of concern because there is little being done to minimize it. First, it's not being spread. There's only going to be one pattern of morbidity experience over the next

20 years, and so you can't spread it by insuring lots of different 20-year periods unless you have a long time horizon. There's only going to be one pattern of experience over the next 20 years, and at the end of that time we're going to tally up the results. If experience was good, you win—if experience was bad, you lose. Second, this risk is not being reinsured. Most companies use excess reinsurance, but that really doesn't help what I'm talking about. You really need stop-loss here, and I don't know that it is possible. Third, it's not being hedged, and I don't know of any financial product that will hedge it. Fourth, product design, for the most part, leaves it in.

I would assert that we are not effectively managing the risk of deterioration in overall morbidity cost.

Let's move on to replacement ratios, which has been a favorite topic of mine for years. There's an old story about a man who robbed a bank, but was unable to make his escape before someone pressed the alarm button. The police showed up in seconds. The quick thinking bank robber ran to another teller, deposited the money in a new account and on the way out the manager of the bank handed him a television for opening a new account. I wonder, from time to time, if that's what we're doing with replacement ratios. The bottom line is that more insurance means higher cost. This is a risk issue because if replacement ratios are high enough, people will exercise their options to become disabled more often. I know that's an odd way to put it, but I think it is an option in many cases.

SOA group long-term disability data show that as replacement ratios go up, the actual-to-expected rate of claim also goes up. Furthermore, according to a study done by the Menninger Foundation back around 1986, as replacement ratios went up, the probability of recovery went down. In both cases, the rate of change was fairly linear, which tells me that higher replacement ratios lead to more and longer claims.

So what is the problem with replacement ratios? They are relatively high replacement ratios at issue. There isn't enough of an offset for social insurance. There are taxable benefits extras. (These are extra amounts given to the insured at time of issue because benefits presumably would be taxable. Unfortunately it turns out that often they're not taxable when the insured goes on claim.) There's something called the group exclusion, where we don't count an individual's group coverage against his or her participation limit. I've never understood that one. The own occupation definition also contributes to high replacement ratios because it allows the individual to work and earn an income and still get paid full benefits. And finally, there are changes in financial condition after issue.

We've done a number of things both as an industry and as a company to try to solve some of these problems. We've lowered participation limits. We have more social insurance integration than we did before. There have been some attacks on group exclusion, which I don't think is quite as prevalent as it was. And we've reduced the availability of own occupation definitions of disability. But one area that we really haven't done much with is the provision of an effective limit on benefit amounts based on earnings at the time of disability. That isn't to say that we haven't done anything. Many companies do have relation-of-earnings-to-insurance provisions, but they don't work very well, as Nick pointed out.

So what's needed? It seems to me that we need two significant changes. First, we need real rate adjustability provisions such as those in group products. Guaranteed renewable is fine in theory, but I'm afraid in practice it doesn't work very well. Some experts will tell you that they do not believe that guaranteed renewable is helpful because needed rate changes won't be approved. Perhaps that's unfair because there's little experience with DI guaranteed renewable. But the experience in the medical market is not good. I believe companies can no longer take the entire pricing risk, and that's why companies are getting out of the business. It feels like it's a time for a change and that's going to require a change in attitude at the regulatory level.

The second thing we need is a relation-of-earnings-to-insurance provision that works like group. The insurance amount should be a function of the insured's earnings at the time of disability, not what he or she was making five or ten years ago when the insured bought the policy. What was appropriate at issue doesn't matter. The need is for a reasonable replacement ratio, but something less than the 100% we're stuck with now, a full offset of extra benefit amounts, (not a rationing down of coverage as in the current coordination of benefits provision), and a full offset of social insurance benefits. I think it's important to point out that no one wins when the insured is forced into a situation where disability benefits make the most economic sense.

At this point, you might be thinking those are interesting things but does it matter? It doesn't matter if we're willing to let this market dwindle until it is totally dominated by one or two companies. We're certainly headed in that direction. If we want a healthy market, I think this does matter.

According to the Life Insurance Marketing and Research Association reports, companies are getting out. The number of companies selling noncancellable DI has actually gone down from 75 in 1984 to 45 in 1994. That's a significant drop, and the situation may be worse than it seems. As a result of exits and consolidations

(not always related to DI), the top ten DI competitors of 1985 have been reduced to five entities today. The competition is dwindling.

In summary, it seems ever since 1990 or so, we've been looking for that quantum leap in DI product design that will solve our problems, because current products don't seem to be working. But it feels like we've simply been tinkering around the edges. Perhaps the ideas you've heard today could be that quantum leap or perhaps they are not. In any case, I hope the discussion has inspired some of you to develop that quantum leap contract.

I spent many years in the DI business and I've enjoyed them all, some more than others. The last ten years have been tough. But I do want to see this business grow and prosper, and I'm concerned that regulatory restrictions are making that difficult. We need real rate adjustability and better control of replacement ratios.

From the Floor: I am aware of the 1985 Society Table. Have there been any Society studies on disability and continuance of disability since then?

Mr. Scarlett: I'm the chairman of the SOA Individual Disability Insurance Experience Committee, and we have gathered data. That data have now been processed and sent out to committee members to review and write a report. The data, unfortunately, are from 1986–91 experience so we're going to be publishing results of that and then getting more current data, and analyzing and making a report on that. I don't know of any more recent industry data that are available. Of course, each of these major companies has been analyzing their experience.

From the Floor: Can you give us any bulletin as to just a general trend from the 1985 table; has it been like a 50% increase or 75% or 25% increase?

Panelist: I don't have a number that I'm ready to give you yet. But clearly, claim costs are up. It is primarily because of a reduction in claim termination rates. Claim durations are just much longer than the 1985 ceded table anticipated. As I've worked with a number of companies, I've seen some company experience that shows some incident rates that are below the 1985 ceded table, but it's more than made up by the deterioration in claim termination rates.

Mr. Edward L. Robbins: Would you describe in a little bit more detail your flexible premium approach?

Mr. Richards: We have not filed our product yet so I'm not going to say too much about it. As Bob indicated, it's not the answer to all the woes of DI. Would it help what we've experienced? The answer is yes. Would it make it go away? No. So

it's just another variation of things we're going to sell, so I'm not going to donate detail about what it is.

From the Floor: My question is for any of the speakers including Bruce. In terms of product design revolutions, is there any likelihood that the future will hold an annuity DI product, something where the clients have a cash surrender value that's like an annuity product? And if they're on claim, some of the payments the income is coming from there are annuity products. So they're sharing some of that risk.

Panelist: I think I'll answer that. I think it's fair to say that before a product like that can be piloted or even generated, you have to go through the focus group that Nick was describing. I can see from a company perspective why we want to do that, but I'm not sure why the insured would want to buy that as long as something else is available.

Panelist: You might also think about some potential regulatory problems with that. It's difficult to get approval of really new product ideas. And I agree with Bob, we need help from the regulators to get more sensible coverage.

Mr. Thomas C. Foley: I have been an actuary with the North Dakota Insurance Department since last October, and four years before that I was with the Florida Department. Let me ramble for a few minutes and ask you some questions. Then maybe I can set up a potential dialogue where we can raise this discussion to the NAIC level, and make some progress. I'll tell you a couple of things. I got a DI filing from a company, which will go unnamed, about three or four months ago. Basically the company was arguing that it would like to set a guaranteed premium and then charge something less than that. This was a stock company, and its argument was this was the way to compete with dividend-paying participating policies. It didn't sound unreasonable to me, but I had all kinds of questions, and wanted to have a dialogue with the company. We ran out of time statutorily, so I had to disapprove the policy. I anticipated the dialogue would continue, but I haven't heard from the company in the last three or four months. I sense from all three of you, because you mentioned regulators, that you see a significant gap between what the companies want to do and what regulators want to do. And I guess I want to ask you whether you are concerned about getting this initial concept approved and/or are you concerned with getting downstream rate changes if you adopt a flexible concept?

Mr. Meilander: My concern would be both. It would be difficult to get it approved up front, but it would probably be more difficult getting rate changes approved down the line. And again, as I said, I think it may be a little unfair in the DI market to make the statement that those rate increases wouldn't be approved because we

don't have too much experience to go on. What I hear from the medical side is that it's tough to get it done.

Mr. Foley: You're absolutely right on the medical side; it is tough to get it done. I'm on that other side. I'm one of the people who makes it tough to get it done. I think there would be significantly different considerations if you all would think about being in a regulator's position for a little while. I know you don't want to put yourself in that position. It's my sense that over the last five or six years, the pendulum, at least at the NAIC level among regulators, has swung 180 degrees about three times. Now we are entering a phase at the NAIC where there's more understanding of and empathy towards the companies' problems. I think you understand that our prime concern is with consumers. I sense that there's a spirit of cooperation that's developing, and that's why I want to get up here and volunteer to be a conduit.

My commissioner is an officer of the NAIC, and because of that, I might have the ability to get some working groups set up. I'd be willing to talk to people individually or you can contact me as a group so we can put little working groups together. I've tried to do the same kind of thing to change the writing of long-term care and, in all candor, the industry has not wanted to even come close to meeting us halfway, so the discussions haven't gone anywhere. It sounds like you have a more immediate need, and it sounds like there may be some unanimity among you. Maybe we can start this discussion. Please understand I'm not promising that I can change the position of New York or California, Illinois or Texas or any other state, but we may be able to raise this to the NAIC level to get more reasons. So I'm available if anyone is interested in talking.

Panelist: That's very important. One of Bob's comments was that quite a few companies have gotten out of the disability business. I don't think anybody is blaming it on the regulatory environment, but in a different regulatory environment, it might be an encouragement for some of those companies to come back into the marketplace, or perhaps even new companies.

Mr. Daniel D. Skwire: I have a question for Bruce. You mentioned in your remarks a focus on worksite marketing, and I think that's probably true for the industry as a whole. I've seen more profitable experience in worksite marketing and pushing the efforts in that direction. At the same time, however, you mentioned the need for broadening the markets to which we're selling insurance. I think demographically we're seeing a shift in many cases. People are moving away from the traditional career path. Companies downsized, and people are working on their own out of their homes. I was wondering whether you could talk about the ways in which

your companies are addressing this kind of phenomenon in marketing and product design?

Mr. Richards: I think Bob said that we're merging some philosophies with some DI philosophies. One of the things about DI is portability. I don't think any of the group products sold at Paul Revere are portable. So I mean it is one of the issues that comes up right away at work site marketing. That becomes an instantaneous focus when we're in the work site marketing environment.

The second thing that I think is more important to us from the DI perspective is that our morbidity experience on groups is better than our individual written business by lots. Therefore, I think what that leaves us with is a clearly identified market. What we have to do is take this boutique market I described, which have these real rich contract provisions, and get them down to a more realistic basis, which is probably much closer to group insurance-type benefits with offsets. It's moving fairly quickly in that direction.

The other thing that I mentioned is that our philosophy at Paul Revere is to solve the need, whether that be group insurance, disability, IDI, or whatever the combination is. We have to get to the point where we're indifferent about that. Internally we're not at this point. Our brokerage people still get paid better for selling IDI than for group referral. That's a big step that has to be taken. I think it's doable, and we're moving there quickly. It is really a further blurring of the group individual markets. A work site can be anything you want it to be. I think that having the right enrollment capability and the right sales presentation is critical. I'll admit, and I told you my background is group insurance, but I'll admit that our individual salespeople are much better at one-on-one presentations than our group people. They think they take the time to do it. We have potential and we just have to harness it in the best way possible.