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Rating Services and Health Care Organizations

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Summary: The panel includes representatives from one or more rating services as well as company representatives who discuss topics of current interest. Subjects covered will include:

- *perspectives of rating services on the ratings of health insurance and health care provider organizations*,
- *critical factors in establishing a rating for a health organization, highlighting differences from traditional life ratings,*
- *primary use and significance of a rating to an organization, including the impact of a downgrade in rating,*
- *what capital levels are appropriate and how they vary from other requirements, and*
- *how the rating service liaison process is designed in the best managed health organizations.*

Mr. John D. Ladley: I'm a partner with Ernst & Young (E&Y) Actuarial Services. I'm based in Philadelphia. We also have Cindy Miller from Anthem and Dave Carlson from Mass Mutual. I will present Manny Nowacki's talk as he was unable to be here. Manny is from A.M. Best and heads up their health organization.

In the several years that I've spent working with a few dozen insurers on their ratings issues, I've concluded that rating services, even for health care organizations, are the most important third-party influence that those carriers have to face. It hasn't always been that way, of course, but it's true in most cases now. I'm not acting as an advocate, nor am I on the "side" of rating services—I want to

make that clear. I certainly don't identify with any one rating service, but I think this might be a little bit of a controversial view, not for life insurers but for health care organizations, so I'd like to develop that proposition a little further.

First of all, sales is an area where we know that insurers are heavily impacted by ratings. In particular, the relationships that companies may have with agents, sales organizations, or with third parties, reinsurers, or others who create markets and customers, are affected by ratings, as are price and product design. Studies show, including a survey that E&Y has done of companies as well as agent surveys, that ratings are increasingly becoming the distinguishing characteristics that agents will use in a competitive marketplace—especially to criticize a competitor and to obtain a sale whenever possible. I expect this to become a more important factor in the future.

E&Y also performed a survey of downgraded life insurers about a year ago, and found that there was significant impact on sales of from 5% to 20% from a downgrade. Usually these downgrades are single class, but sometimes they're more serious. Many health care organizations have only been rated for a relatively short period of time, I realize, and very few have actually been downgraded. The average rating, as you'll hear from Manny's talk, is in the A/Excellent category, as far as A.M. Best is concerned. I don't know that health care organizations have really felt the impact on their sales or even their in-force business of downgrades and uncertainty concerning their ratings in their markets. I have personally seen in the past few months the impact of a potential rating downgrade on large-case health sales for an insurer. I've seen another insurer very materially impacted on writings in its “group life only” contracts through third parties who became squeamish about its ratings future. I've seen a number of situations in the individual disability income health line where ratings have been a problem.

Cindy Miller will elaborate further on, whether there's also the obvious ratings impact on cost of money, capital levels, and the access to and management of capital. If insurers are not considering rating services’ views when they look at their capital but are continuing to look at the National Association of Insurance ’ (NAIC) basis or what they feel their own version of capital should be, then I think many of them are probably missing an opportunity and also creating a risk for themselves.

One chief investment officer was recently quoted as saying that the rating services were doing more to influence his investment decisions than any other organization or person inside or outside the company. From what I've seen, I think that may be largely true in many companies. Services can have a very material effect on the investment function. Other areas, such as conservation of new business and operations, are also affected by ratings.

I consider the rating service package, while not always perfect, a very neat sort of "company-in-a-box" kind of tool if used effectively. In most engagements I plan, especially in due diligence, one of the first things I look for is the company's presentation to the rating service. I think this shows a lot about its plans, how it perceives itself, I also check to see if it has a nice, concise package of materials that support plans with financial data. At least that's the way they should look, and if yours do not, they should. You are well advised, in my opinion, to give significant corporate attention to rating service views and their impact. Analysis that we have done on a company indicates that a single rating tick, as I mentioned, is worth potentially 5% of value. By tick I mean A to A-, A+ to A, B++ to B+, or similar moves in one of the other ratings scales. I'm just using a Best scale here.

We've also found that notice of downgrades (when they do occur) from the company's perception are relatively short. The vast majority of those from the company's view are with 30 days or less notice, and the majority of companyperceptions of downgrades is that notice is seven days or less! The rating services, I know, would tell you that they have given repeated warnings to companies that eventually are downgraded throughout that process. Sometimes services claim it's six months or a year. My experience is that it's sort of a mixed bag, somewhere between what the companies perceive and the rating services think, but you should be aware that the companies are frequently quite surprised by the rating service action. Maybe the other panelists will be able to comment on that as well.

Lines of business vary, of course, as to the impact that ratings have on them. It is true, and I have plenty of experiences to show, that some coverages such as dental or administrative services only, credit and short-term disability (STD) can be sold with "below investment grade" or "vulnerable" ratings. There is pressure for better insurer ratings. Ratings will become more important, especially as all the markets become more competitive. So, I believe today's situation where you can be in certain lines and be successful (or at least growing) without a real high rating, will change. Of course, very few lines will reach the importance of ratings to a guaranteed investment contract (GIC)/pension-type line.

It's interesting to note there are health lines where ratings should and do have a significant impact. Maybe most of you represent group health or managed care writers, but there are also accident and health lines like long-term care, long-term disability, and individual disability income where ratings matter a great deal.

As I mentioned before, health care entities, and these are largely health maintenance organization (HMOs) and Blue plans, are rated primarily in the A category, and so far there is little reaction to lowered ratings in this sector.

The rating services see many styles of what I'm going to call the company liaison function. By liaison, I mean those people and the whole process that's used to make contact between the insurer and the rating service. Some analysts may deal with a couple dozen such liaison functions. Some analysts I've run into see up to 50 or more companies. The degree of homogeneity of the companies is also being increased by the services. So services may see, for example, if you're in a STD line, anywhere from five to ten carriers who are also in that same line. And so it goes for payroll deduction or for group life only. That gives services a fairly broad perspective and experience in your line. They hear from managements, many of them quite capable, in the same line, over and over. You're really being compared to them and, hence, peer group comparison is very important.

These rating services do see the best performing managements, and they can identify them if you ask. For managed care, an individual life, or a pension line, or for a company that does a lot of mergers and acquisitions (M&A), the rating services can tell you who they think the top companies are. I think that's an important implication because, in a sense, what they're really telling you is these are well-run companies with good managements that you are being measured against. I haven't memorized Manny's speech, but I did see his reference, not surprisingly, that the qualitative factor of management and its capabilities plays a very key role in the rating service's decision making. In fact, I think A.M. Best says qualitative factors now account for more than 50% of their rating.

In short, the more playful and thorough managements who have a favorable story to tell, and tell it well, position themselves better. And weak, disorganized liaison functions are a problem. My contact with the services, without a doubt, tells me they will say that they see far more companies with a weak and disorganized liaison function than with a strong one. That is the rule. I conjecture that 60–70% or so of the industry that approaches the services falls below the kind of minimum liaison standards, let alone the "best practice" standards, that they'd like to see.

The classic, old-line liaison function looks and sounds like this. It's staffed by one part-time person who has a lot of other things to do, usually a corporate actuary or maybe a chief financial officer. They may really only work on it essentially once a year when there's about a one- to two-week fire drill to get the presentation together, gather up the plans and financials, and try to put a positive spin on them. Insurers typically perceive there to be ratings biases, and in some cases, they're right. Size, in surveys I've seen, is one of the most frequently mentioned biases, and it does exist to an extent. However, the companies with weaker liaison functions, I believe, allow the biases to grow sometimes into conflicts or an irreconcilable issue that dominates their thinking about the service. That keeps

them from developing more effective outlooks and practices to deal with all the other issues out there.

Such issues might include size. They might include their capital levels, their underwriting gains, their position in collateralized mortgage obligations (CMOs), some disfavored lines of business as they perceive them, that they feel the service is trying to get them to close. Any of these can create ongoing conflicts and it hurts the dialogue process, which is a very serious problem to have.

Profiling an insurer that's following best practices really starts with their attitude on ratings services and the way the liaison practice is designed. These top companies, and I consider the two that my panelists represent to be among them, devote significant staff and time to the rating service liaison. Further, they recognize the rating services, at least the big three, are different in their approach, and they try to recognize those differences. They can't all be handled the same way, and sometimes those differences are important as you are presenting a merger or acquisition transaction, or opening a new line of business, or trying to preserve a rating.

Top companies do not allow biases to affect their entire relationship with the organization. They also make more of a year-round effort, and it tends to be integrated into their planning effort. Naturally that's something that would happen when you start to move someone who's more on a full-time mode into this liaison function.

Here are some of the specific best practices that are followed. First, I think it's highly valuable to perform a detailed peer group analysis of companies. That involves looking at the companies that are currently at your rating level—not when you're most fearful of a downgrade, but instead when you're optimistic about the possibility that you should move up in class. At that point you should be looking at the companies that have the next highest rating. There's a lot to be gained by doing peer group analysis currently. It keeps you up on ratings trends. It also gives you and your management more of a perspective on where you sit as opposed to thinking you're the only carrier or HMO out there that has a particular problem. (That's not necessarily true at all.) The most important determinant in creating a peer group is size, and the second (close behind) is line of business. It's fairly easy to generate a peer group or to approach the service about it.

Second, I would suggest watching the developing changes in the rating service positions, on the product lines that you're in, perhaps your type of company, or what's happening to your peer group companies. There are group downgrades, as groups of mutuals, smaller stock companies that have a single or narrow geographic

focus, or other types of organizations have found in the past. There are changes in service views of certain product lines from time to time that are quite significant.

Rapid response capability is third. One of the better examples I can give you on the life side is in the CMO investment area. Numerous companies have gotten into a heavy CMO position and some in the more exotic CMOs. Sometimes they get into a conflict situation with the rating service about how those work, whether they're appropriate, how well they match their liabilities, and how much the company knows about them. However, when the rating service turns around and asks some of those companies to provide models under specified scenarios or some other basis, sometimes it can't be done at all, and sometimes it takes the company one, two, even three months to respond to those kinds of requests. Then we've had a company with a heavy position in a fairly significant invested asset, and the company really can't back it up with compelling analysis. Again, this relates as much to management as technical capability.

I think company best practices and capital planning provides an excellent example, include drilling down to the level of the organization that can make decisions affecting an issue. The rating services, particularly A.M. Best, are looking for indications that the company communicates and emphasizes its strategy through the use of such tools as incentive plans to the people who must implement the strategy. They've gotten pretty serious about making sure the whole organization knows where the boat is going and is all pulling on the oars.

Finally, in a continuous improvement environment, these are the companies that work 365 days a year at their rating service liaison function, because they know it adds value to them.

At this point I'm going to read Manny Nowacki's presentation into the *Record.* Manny is the head of Best's rating service for health care organizations. He was formerly with Best, then Moody's, and he went back to Best again. So he has seen a couple rating service approaches to the health marketplace.

A.M. Best was the first company in the world to report on financial conditions of insurers. Best publishes numerous publications, as you all know, and has expanded to worldwide coverage. In the past decade Best has grown significantly in the area of international ratings, specifically for companies operating in Europe and Asia. As part of its expansion and ratings, A.M. Best introduced an HMO statistical publication in 1994 and introduced its first HMO ratings in 1995.

Best's total worldwide rating covers 3,600 companies. A.M. Best rates more than 1,200 life/health companies and 2,000 property and casualty companies. Our two

expansion areas, while relatively small in relation to the other ratings, account for a growing number of ratings coverages. This includes 269 international ratings and 76 HMO ratings, for a total of 3,601 total ratings. Financial performance ratings account for about 500. Financial performance ratings are numerical ratings, ranging from one to nine, that are generally assigned to new companies or to start-up companies that are only developing their business strategies. Bests' Rating Categories are:

Secure Ratings:	
A++ and A+	Superior
A and A-	Excellent
B++ and B+	Very Good
Vulnerable Ratings	
B an B-	Fair
C++ and C+	Marginal
C and C-	Weak
D	Poor
E	Under Regulatory Supervision
F	In Liquidation

The A.M. Best rating scale has somewhat fewer rating categories than those utilized by a number of other rating services, so I think it would be useful to spend a short moment describing the rating categories to you. Our rating scale includes 15 different rating levels ranging from A++ to F in the two major categories of secure and vulnerable. In addition, these rating levels are grouped into categories. For example, the "superior" category contains the levels A++, A+, while A and A- companies appear in the "excellent" category.

Let's focus on the total health care rating coverage for specialized health care companies. By specialized we are excluding commercial insurers—multiline companies—such as CIGNA and Prudential. Meanwhile we also rate 19 different Blue Cross/Blue Shield organizations and 76 HMOs. Most of these ratings have been completed in the past 30 months as part of our strategy to increase our presence in the health area. Also, the 76 HMOs represent 19 different HMO groups. So there's really a relatively small number of corporate groups there. I will go into in more detail later.

Our rating coverage for Blue Cross and Blue Shield companies is extensive. Most Blue Cross and Blue Shield ratings are in the central part of the country, although Best does have a number of ratings on the coasts, including Blue Cross of California, Washington, Alaska, and Connecticut.

Of the 76 HMOs we rate, they fall into 19 families or groups of HMOs. All ratings within a family are not the same. Nevertheless, this is a fairly strong group of companies with an average rating of about A-.

In assigning HMO ratings, we do what I describe as both a top-down approach and a bottom-up approach. By top-down we refer to an analysis of the strengths or weaknesses of the holding company and how those strengths or weaknesses may impact on the operating HMO company. Similarly, we also make an assessment on the particular challenges or advantages at each operating company and make a judgment on how these may affect the parent. In essence what we do is develop an ultimate, internal rating at the parent or major operating level and then haircut these down as appropriate for specific operating companies. On a stand-alone basis, the local subsidiary may have somewhat greater challenges or weaknesses than the stronger affiliates within a family.

The lower-rated companies within a group tend to be either relatively new organizations, may not have a long-term track record, or may be in particular markets with major business challenges. This reflects our view that a parent organization can withdraw from particular markets if it believes that it cannot meet its profitability objectives. This has occurred a number of times within the past year at some of the entities we rate. For example, Humana recently sold its Washington operations to Kaiser, and Pacific Care withdrew from the Florida market. Both withdrawals were due to poor performance at the local HMO operating level.

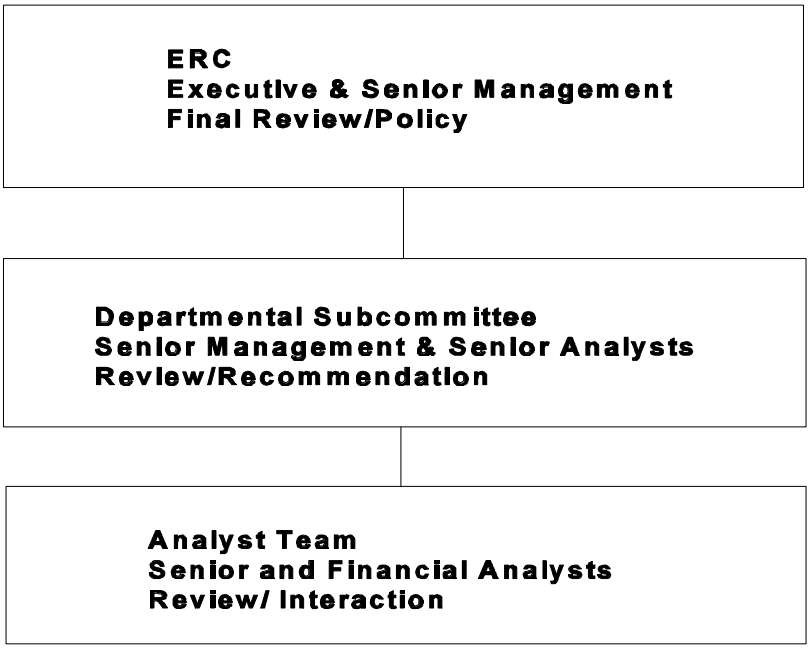
We try to set the tone on how we view the health insurance market as we rate health insurers, HMOs, and Blue Cross/Blue Shield organizations. We see the market undergoing rapid change. Health companies are seeing their roles changing from being providers of care to being managers of care. As a result, our analysis is evolving towards assessing the effectiveness of the insurer or HMO in managing medical costs. The rapid rise of health care premiums over the past decade has resulted in employers looking for more cost-effective medical coverage and has spawned growing competition from many of the players, particularly fueling the growth of the HMO industry. When we rate insurers or HMOs, we look at the nature of the competition and note that there are different players in each local market with competition, including other types of organizations, such as preferred provider organizations (PPOs), third-party administrators, and Blue Cross organizations.

How does A.M. Best goes about its health ratings? First, it has been rating commercial health carriers for many years, including multiline companies that have health insurance, individual or group. Also, we've rated niche commercial players or mutual life and health insurers that have focused on health insurance as well. We use this background to leverage our expansion into the rating of Blue

Cross/Blue Shield plans and HMOs. Not to say that HMOs can be or should necessarily be compared to indemnity companies, but A.M. Best has developed a good degree of expertise and understanding of health insurance. This began primarily with some of the multiline companies. It also reflects various longer term relations with life subsidiaries of HMOs that have enabled us to add to our understanding of the industry. A.M. Best's analysts who follow HMOs and Blues are a specialized team of individuals within the organization. They have diversified industry experience, coming from both indemnity and HMO backgrounds. In addition, there's a strong integration, by which I mean we have an HMO and an indemnity insurance analyst attending each other's meetings and participating on each other's rating committee.

The process shown in Chart 1 illustrates the analyst's role in working up the overall rating process. Working from the bottom of the chart up, the analyst is responsible for gathering and analyzing the information on a company and making a rating recommendation to his team leader, including his peer's analysis. There is a significant interaction within the analytical team and with the company being rated. From there the rating recommendation and appeal process includes a department subcommittee, which includes representatives from different analytical teams. The ultimate rating committee typically reserved for rating appeals and higher profile situations is the executive rating committee).

CHART 1
A.M. BEST RECOMMENDATION PROCESS



The rating process, from the point of view of the company is very interactive and includes extensive communication between the company representative and the A.M. Best analyst. The flow of information is critical and includes both quarterly and annual updates. The most important portion of the rating process is the annual company meeting with senior management, typically at the company's home office.

New relationship management meetings usually include a corporate overview in a session with the chief executive officer (CEO) to discuss strategic issues. During the meeting we try to get an assessment of the company's competitive position within its markets. For each business unit we discuss the characteristics of the major products, current and expected future profitability, and product development strategies.

The financial overview includes discussion on capitalization, profitability, and liquidity. In discussing profitability we discuss a number of factors, including market focus of the company's business segments, competitive dynamics of the market segment, relative distribution costs, underwriting record and outlook, investment strategy, and management planning and control systems. Our approach involves an assessment of these factors in order to reach a conclusion about expected long-term profitability and the risk that actual results may deviate from these expectations over a period of time. Our analysis of liquidity considers marketability and liquidity of the investment portfolio, as well as alternative sources of liquidity, such as bank lines of credit. Discussions take place regarding the investment center and the composition and performance of the investment portfolio.

More than just the statutory statement is utilized in reviewing the performance of a health insurer or HMO. In addition to the statements, we rely extensively on NAIC annual and quarterly statements, a supplemental questionnaire, various state exams, CPA audits, stockholder and policyholder reports, Securities and Exchange Commission filings, business plans, and the management meeting itself.

We review various quantitative ratios over a multi-year period and analyze the trends within the various categories of utilization, enrollment, profitability, leverage and liquidity. These ratios are compared to an insurer's or HMO's peer group results as well as to A.M. Best's standards. An example of a utilization ratio that we review is hospital days per thousand members. However, we believe that an HMOs statistics must be looked at relative to the HMO's local markets. For example, 250 days per thousand may be a good result in the mid-Atlantic states, but would be considered high in other states. Take California HMOs as an example, where they tend to manage their hospital days to under 200 and Medicare to about 1000. On a national average, meanwhile, Medicare is running much higher than 1,500 days.

Let's discuss enrollment trends. We believe that the size of enrollment in a local market is important because a large pool of members provides the HMO with significant clout with which to negotiate substantial discounts with hospitals and providers. We also look for employer concentrations and turnover within the client base. Finally, we review various profitability, leverage and liquidity measures, both at the operating company and consolidated holding company levels.

The qualitative analysis includes various factors. First, in reviewing different health insurers and HMOs, it is important to evaluate the markets in which the company is competing. Our analysis considers the organization's competitive advantages and its major market segments, and also assesses major challenges facing the company in these markets. In reviewing the business segments, we consider the key competitive issues within its market segments, including the nature of the competition and the dynamics within the geographic area. We consider the regulatory environment. We monitor potential regulatory changes and attempt to assess how potential legislation may impact on the company's operations. For example, the current Medicare reform debate could result in significant operational changes to select companies. I guess that's actually a continual debate. We also monitor various state initiatives and review any potential risks that these changes may have to specified managed care organizations. In reviewing the organization's relationships with providers, our overall analysis attempts to assess how the company manages its relationships with providers, and how its provider agreements impact on profitability.

For HMOs we consider the nature of the contractual arrangements with providers and consider how risks are shared between the HMO and the provider network. Discussions regarding an HMO's provider networks tend to lead the quality of care. We believe that proper monitoring of provider utilization is essential, and the utilization needs to be carefully monitored or an HMO could be facing quality-of-care problems. Some of this can be statistically observed. For example, if an HMO is managing hospital utilization downward, we would expect other utilization measures, such as outpatient, to rise. We are also keenly interested in the emphasis which quality of care receives from senior management of the HMO, and we try to ascertain what role quality of care plays in the HMO's corporate philosophy.

Next we have a technology and service capability area. Here we try to determine how management utilizes technology in helping to administer and manage its business. We consider the technology and systems capabilities the company employs in managing various aspects of its activities, such as utilization, quality of care, electronic claims-paying ability, and physician credentialing. We also consider additional investments that the company may need to make in order to maintain or achieve a competitive level of technological capacity.

Next is expense management. As managed care penetration continues to increase in many areas of the country, we expect that competition will rise significantly and will become more intense. This has increased competition and is expected to create market forces that will keep premium rates down and drive loss ratios up.

Capital management has been an important area given the rapid pace of consolidation that has taken place in recent months. A.M. Best's analysis attempts to take into account the aggressiveness of management's growth strategies and what impact possible acquisitions may have on an HMOs current capital structure. We also try to assess the capital strength of the organization after the acquisition. Finally, the last point is the relationship of the operating subsidiary to its parent. This analysis includes review of the parent organization's financial position, including the amount of financial leverage within the organization. We also consider what benefits and strengths an HMO receives from its parent organization. This could include actuarial, underwriting, investment or other expertise, access to systems and technology, and access to capital.

Let's cover some of the trends we see in the HMO industry. There is a major trend of geographic expansion by HMOs away from the historical, core markets. Much of this is being driven by a number of California HMOs, who are facing a mature market in their home state. This expansion is being accomplished through both mergers and acquisitions, although there are a number of situations where new entities are being created. Generally, we review controlled expansion as favorable if the expansion complemented existing activities and allows the HMO to transfer its expertise and knowledge to these complementary markets. Product expansion is also something that enters into our rating discussion. Although we tend to view controlled expansion into new products favorably, we are cautious and pay careful attention to the expertise that the company may have as it undergoes these product expansion strategies.

Capital management was discussed briefly before. Let me add that our analysis attempts to take into account the aggressiveness of management's growth strategies and what impact acquisitions will have. Last, we consider management and note the experience of the management team. Although a subjective quality to measure, it is an important determinant of the rating process. Our review of management is based on our face-to-face meetings with senior management. We consider the goals and motivations of the management as well as management's experience. In some instances, a rating decision may be partially based on our assessment of management's ability to successfully implement a new or constructive plan of action to enhance policyholder security.

Ms. Cynthia S. Miller: I will discuss the rating agencies from a health insurance company perspective. Before I start, I'd like a show of hands. How many of you have had much interaction with the rating agencies? Because I might change some of my comments based on whether we have a group that's pretty experienced or a group that's pretty new. If you have had interaction, raise your hand. It looks like not very many.

First, I'd like to tell you a little bit about the company I work for so that you know what kind of experience we've had with the rating agencies. I work for Anthem Insurance Companies, Inc. We're a mutual insurance company domiciled in Indiana. We write predominantly indemnity and managed care health insurance. Those are our major lines throughout the U.S., but our main claim to fame is that we're the Blue Cross and Blue Shield plans in the states of Indiana, Kentucky, and Ohio, and the vast majority of our revenue is derived from that business. It's about $4.5 billion a year. We have total revenues of $6 billion. Of the other $1.5 billion, about $1 billion is from what we call “unbranded” plan business that's written outside the tri-state area and doesn't use the Blue Cross/Blue Shield mark. Then we have $500 million of miscellaneous other lines. We're a strong company. We have about $5 billion in assets, of which $1.3 billion is statutory surplus.

Up until about eight or nine years ago we only had the traditional Best rating that Jack described. That's considered a financial strength rating if you haven't been involved with the other rating agencies. We didn't do anything that necessitated any other kind of rating. And then about eight or nine years ago we had a massive management change, and some of the new folks that came in wanted to access the capital markets. In order to do that, we had to be rated. What started the process was a commercial paper program. If you're not familiar with that, it's basically sort of a line of credit with banks that allows you to cover short-term, cash-flow needs. In order to decide what kind of rate they're going to charge you for accessing that line of credit, you have to get rated. That was when we expanded beyond Best's to the other rating agencies, S&P, Moody's, Weiss, Duff & Phelps. Since that time, we have been active in different kinds of transactions and deals, and all those things potentially impact your ratings. So every time you do one of these you have to have interaction with the rating agencies to make sure that you don't get downgraded or that maybe you potentially even get upgraded because the deal's a good thing for your company. And even some of these things, like the surplus notes, require a separate rating of their own.

Financial strength, sometimes called claims-paying-ability ratings, is an area we're rated on by all of those companies, although the Moody's rating is one we'd like to get rid of. I'll talk more about that later. The short-term debt rating is primarily the commercial paper program that I mentioned. Then we've done two 144A ratings,

also called a private-debt rating. (It is not published—as it's only for the particular investors.) One covered the recent surplus note issue. The short-term debt is rated by S&P and Duff & Phelps. The private debt, the surplus notes, were rated by S&P, Duff & Phelps, and Moody's.

I asked how many have been involved in the rating process because I want to talk about it, but not if you've all been through it. The first time you go to a service that hasn't rated you before and say, "we're going to pay you, give us a rating," is by far the most intensive, because the company really has to get to know you. Manny's presentation made this pretty clear. They have to get to know you, your products, your management team, your history, your strategic plan; and so they're really going to grill you. Generally what happens (and there are some exceptions, and I'll go into those later) is that they assign a lead analyst to your company. That lead analyst is the one that's responsible for requesting the information from you. They will be your main contact person, not only in the initial rating process, but throughout the whole rating process. They analyze the information, and then they're the ones that make the recommendation to the rating committee.

During the initial process they'll send you an information packet with lots of information in it. But the most important pieces that they're going to ask for are detailed, historical, and projected financial information. Generally they consider five years of each to be optimal—five years historical, five years projected—and they're also going to look for a lot of detail. The more detail that you can provide them with the better they like it.

For a managed-care company the kind of detail that they're going to be looking for, at the very least, is going to be by product line: HMO versus PPO versus point-of-service and indemnity. You're going to want to separate all those things, if you can do it. You also need to separate it by geographical region, since the forces in the different areas of the company for managed care can be very different. Obviously, what you can provide is going to depend on how you run your particular company, but they like a lot of detail.

They're also going to ask for what we call an environmental analysis, which falls into the qualitative assessment that Manny talked about. Again, there's going to be some generic things there for all insurance companies or any industry really—your competitive analysis, your regulatory environment, and what kind of growth you've had, and what kind of strength your management team has. When you get specific to a market like managed care, they're going to want to know what experience your management team has in managed care.

They want to know about provider relationships you have, whether you have National Committee for Quality Assurance accreditation for your HMOs, and all those types of things. Finally, they're going to ask for a copy of your strategic plan. We found that they put a lot of emphasis on your strategic plan. What they do is they take your strategic plan and they compare it to their assessment of the environment that you're operating in and see whether they think it makes any sense at all. Finally, they're going to follow that with an on-site visit, and Manny mentioned that. We find the on-site visit to be tremendously important and, again, this agrees with what Manny said, because that's where they get to know your executive team. They get to know, much better than they can on paper or via phone call, what your management team's strengths and weaknesses are.

We also like to include an initial social period. They generally come to our company for meetings, although I don't know why, so we have continental breakfast, and we'll invite more executives than just the people that are formally presenting. For example, I'm our chief actuary, and I'm never present, but they always like for me to come because that gives the analyst an opportunity to ask actuarial questions, to meet me, and to get comfortable with how I fit into the picture.

Once the on-site visit is done they'll have some follow-up questions. Also our treasurer, who is our main interface with the rating agencies, suggested that you don't give them a lot of time between the time that you send your packet and the time you schedule your on-site visit because it gives them too much time to dream up crazy questions. That was his comment. Anyway, once you've gone through their follow-up questions, then the lead analyst will make a recommendation to the rating committee. It's really important at this point that you have forged a good relationship with that lead analyst, that they truly understand your company, and that they believe in your strategic plan and your business plan because they're going to act as your champion in front of the committee. We've gotten into situations where, at least according to the lead analyst, they want to give us one rating and the committee's pushing for another one. They're going to act as your champion, and if they don't truly believe in your vision, your strategic plan, your company, and your management team, they're not going to be able to adequately represent you, and you obviously want to maximize your rating.

They will let you get a draft or they'll give you feedback before they publish the rating. There's a very short window of time, usually two weeks or less, where you can challenge that rating or make comments. We haven't been tremendously successful in getting them to change their mind, but sometimes they have misunderstandings or misinformation that can be corrected. So you really need to take that review seriously. Finally, they'll do a news release. Again we always

review a draft of the press release because it can have typos in it. It can have misinformation in it, or it can just present things in a way that is not totally inaccurate, but it's not really the way you want your company to look. So, we take that piece of it pretty seriously.

The ongoing rating process is similar to this. It's not as intensive as the first time, except that the rating agencies like to change your lead analyst periodically. They either leave and go someplace else, or sometimes I think the rating agencies do it deliberately because they like to have a fresh set of eyes look at your company. Every time you change your lead analyst you basically go through the initial process all over again. If you're not going through the initial process or they haven't changed your analyst, then you're going to send them your quarterly financial statements. We don't just send them our quarterly financial statements. We make a phone call and say, "Here's how we did for the quarter. It was better or worse than planned. Here's why. Here's where we think we're headed for the rest of the year." And so we use that opportunity to have face-to-face contact again.

They're also going to have an annual on-site visit. Manny said they like to have it at the home office. We like to vary it because we have subsidiary operations that aren't just at our home office. That way they get to meet those executive teams, too. We have a corporate office, but then we have business divisions where they're really running the business, and it's important that they get to know those folks. Finally, the last thing is, it's really important that any time there's a major development in your company, you need to let those rating agencies know before it hits the news. They should not find out about your company first in the newspaper. They should hear from you that this is going to happen before it happens. Sometimes you can't help that, but you should minimize it as much as possible.

I'll discuss Anthem's view of our experience of what the key measurements are. I found it interesting to hear what Manny said because I didn't think he necessarily keyed on these things as much as we think the rating agencies key on them.

Of the quantitative ratios, the most important has been capital adequacy. All the rating agencies have their own risk-based-capital-type capital adequacy formula. They tend to be similar to the NAIC life/health risk-based-capital model, but they're not identical. They either look identical, except they have different risk factors, or in some cases they can be quite a bit different. In all the experience I've had, they're more stringent than the life/health risk-based-capital model. I think Jack made a comment that if you're dealing with the rating agencies, you can't just look at capital adequacy in terms of the NAIC model—just because you're OK by the NAIC model doesn't mean you're going to be OK by the rating agencies' model. They also tend to be more subjective than the NAIC model. There is a risk factor. If

you write Medicare-supplement business, the risk factor is—12% or whatever. No matter who you are and where you do business, that's the risk factor. The rating agencies, especially S&P, feel very free to vary the risk factor that they assign to a particular risk based on who you are.

Let me tell you about one of the things that they've done to us as an example. We have a casualty subsidiary, and they've never liked the fact that we have that casualty subsidiary. So even though, by the NAIC model, that casualty subsidiary is very substantially capitalized and has excess surplus that we should get credit for, we take a 100% haircut for that. In their model, 100% of the investment in that subsidiary is required to capitalize, to support that subsidiary, and so we get absolutely no credit for the surplus from that company. I'm not trying to complain; I'm just trying to point out that you need to be careful.

Another measurement that's very important, especially for health plans these days, is return on revenue. Obviously, if you don't have return on revenue over the long haul, your capital adequacy's going to suffer. Also it depends on what kind of rating you're getting. If you're getting a debt rating or one of those, they want to make sure you're going to make money so you can pay back the debt. Right now for return on revenue I'd say most of the rating agencies have an expectation for managed-care plans in the range of 2–6%—you're supposed to have a return that's about 2–6% of premium.

Investment performance and its quality can be big issues. It isn't for us because our investment quality has been pretty pristine, but if you're very aggressive in investing it can hit you. For most health plans that's not an issue, but it also could be an issue if a lot of your assets are in medical property and equipment, where it might have a questionable value. Then they're going to take a look at that because it implies something about the strength of your balance sheet.

There are a couple of measurements that we found to be important but may not be as significant as these. Growth is important they like to see that you have continuous growth. Financial flexibility is important. They're also real big on reinsurance protection, especially for smaller plans where they want to know that there will not be some catastrophic hit.

Most of the rating agencies also use what I would call qualitative measurements. The exception to that is Weiss. Weiss doesn't want to have any interaction with your management. There's no on-site visit. They don't ask you for an environmental analysis. I don't think they've ever asked us for our strategic plan. Their philosophy is that we crunch the numbers, and whatever the numbers say is what your rating should be. I don't particularly agree with that. That's my personal

opinion, not the opinion of the Society or my company, I think these other things can have a serious impact, but their view is that they don't want their analyst to be influenced by your management team. They want to just take a hard look at the numbers. But all the other rating agencies that I'm aware of use qualitative measurements, and that's when the on-site visit and the environmental analysis comes into play.

I think I'm obviously in agreement with Manny when we say the strength of your executive team is very important, both their experience in managed care and their ability to articulate your strategic plan and also tell how it fits with your business plan, and how your business plan tracks to your strategic plan. They're going to look at the strategic plan itself, and then there'll be the overall environmental analysis, and I went into that earlier.

Market position is really part of that environmental analysis, but I separated it out because it seems to be such a focus these days of the rating agencies. The consensus is, especially if you're trying to be big into managed care, that in order to get the kinds of agreements with providers and the leverage with providers that you want to have, you must have significant market share. This is one of those damned-if-you-do-and-damned-if-you-don't things because if you have too much market share then they worry that you're too concentrated. You can't grow anymore. The only thing that can happen is that other competitors can come in and erode your market share, and so it's a strike against you. So you've got to fall in that middle ground where you're one of the dominant players, but you don't have so much market share that you have nowhere to go but down.

In the environmental analysis there are two areas where I think health plans are in a Catch-22 these days. The regulatory environment is viewed as being hostile by the rating agencies because of all the legislative activity trying to mandate benefits and those kinds of things. Also the competitive analysis, which is part of the environmental analysis, is also a no-win situation because the competition is viewed as being so fierce.

We've developed some rules for dealing with the rating agencies. The very first one is, if you're thinking about entering into a new rating relationship, before you do it, ask yourself, do I really need this to run my business? Do I really need to access the capital markets? Do I really need S&P to give me a financial strength rating? It's a relationship that takes a lot of hand-holding, and you're not guaranteed that you're going to get the rating you want. And, once you get them to start, you can't get them to stop.

A case in point is that eight or nine years ago we started with more than Best's; we asked Moody's to rate us. Our Moody's ratings consistently came in one to two notches below everybody else, and we didn't believe it was warranted. We worked with them over several years trying to convince them why we were better than that, and we just couldn't do it. So we stopped paying them to rate us. They still rate us to this day, and we still don't like the ratings they give us. They don't have any on-site interaction with us anymore, but they take the publicly-available information and develop a rating, and there's nothing we can do about it. So you need to bear that in mind.

The second rule is, no surprises. I think Jack pointed on this. You need to designate one individual who's responsible for interacting with the rating agencies. Ours happens to be our treasurer, and, contrary to what Jack said, it is a part-time job for him. Maybe we're not doing the best job that we can, but we do take it very seriously. Designating one individual allows two things to happen. It lets that person develop a rapport with the lead analyst and allows some trust to develop. It also makes sure that you don't have two executives who miss or not communicate something to the rating agencies, and who are saying to each other I thought you were going to do it. So, make sure one person is responsible, and make sure the person knows he or she is responsible so they can take that job very seriously.

We like to have a partnership philosophy with the rating agencies. We tell them things that are confidential before it becomes public. We want them to feel like we really trust them and that they should trust us. You have to deliver on your commitments. If you say, "I'm going to get you information by next Friday," you must get it to them. That's the little stuff or the big stuff. That means you follow a business plan that's consistent with the strategic plan that you've communicated to them, and you also make good on your earnings forecasts.

Now, I'm not living up in the castle in the sky. We have changed strategic plans. It's not that you can never change. In fact, one rating agency recently joked with our CEO and asked him what our strategic plan de jour was. So, it's not that you can't change. We certainly have missed earnings forecasts. When you change your strategic plan you don't say, "I wasn't wrong before or you heard me wrong." You say, "Our environment has changed" or "What we were trying to do didn't work, and here's what was wrong, and we're going to go forward." The same thing goes for your earnings forecasts. You say, you goofed. You missed our earnings forecast, but have analyzed the problem. You say "here's what it is, and here's what we're doing to fix it."

This is just an example for you of what it takes to be AA rated by S&P. I think S&P's AA rating would be akin to an A or an A+ for Best's. It's not their very top tier, but it's pretty far up there. And this is their criteria. I won't read them all, except I will

point out that the excellent risk-based-capital ratio means that you need to have at least 150% of their target surplus. So you need to have 150% or more, and that's going to be considerably more than 150% of the company action level, risk-based-capital level is considerably more. If you want to be A rated, then all that stuff drops down a notch. Instead of having dominant market position, you need to be strong. You need to be even with the market in your managed care capabilities, and you need to have what's called "good risk-based capital," which would be between 125% and 150%.

I'd like to go through a couple deals that we've done recently and how we treated them. This demonstrates you what can happen when you announce a deal. Services almost never say it's a good thing. If they think it's a good thing, they put you on credit watch with neutral implications, which means they don't think your rating will change. If they're not sure what it means, and they need more information, they'll put you on credit watch with developing implications; and if they think it's bad, they'll put you on credit watch with negative implications, which means there's a strong likelihood that your rating's going to get downgraded. We've been in each of those three positions at one point or another.

One recent deal that resulted in basically no reaction, was our recently announced sale of our casualty subsidiary, Anthem Casualty, to Vesta. The way we approached that was several years ago when we changed our strategic plan from being one of diversification to one of focusing on health insurance as our core strategy, we told them that included the possibility of divesting non-core holdings or non-managed care holdings. Then in 1997 when we decided to put Anthem's casualty operation on the market, we called them and told them we were putting it on the market before it went on the market, and we told them why. We reiterated the tie to our strategic plan. And then as the deals progressed, as bids came in, we let them know whether it looked like it was going to be a bottom line hit or a good guy on the bottom line. Then when we got ready to sign with Vesta, we called all the rating agencies and said, "This is going to go out tomorrow, and here's what it means." It was probably going to be a good guy for us, so we let that be known. For smaller deals, and we've done smaller divestitures, we wouldn't keep calling them again and again, but it's very important to keep that level of communication going.

On the flip side, last year we announced we were merging with Blue Cross/Blue Shield of Connecticut and Blue Cross/Blue Shield of New Jersey, and both mergers resulted in our being placed on credit watch with negative implications. The reason for that was that the rating agencies viewed those deals as being dilutive to our capital. They thought it was going to make our capital adequacy position suffer. That credit watch has since been removed with no downgrade, and the way we accomplished that was again to first communicate to them. We told them "Look,

this really fits with our strategic plan, something we told you we were going to do." We showed them a lot of pro forma financial and other things, and capital projections that showed them that over the next three years we were going to end up being a lot stronger than we were to begin with. We would have proceeded with the deal even if they had said you're downgraded, but it would have given us serious pause.

Mr. Ladley: I should mention that Cindy Miller started her career with Indianapolis Life. She is currently chief actuary of Anthem.

Dave Carlson is our next speaker. He's from Mass Mutual. Dave was in the individual financial division of Mass Mutual, but he has been a corporate actuary responsible for various special projects, including M&A work, an area where Mass Mutual has been active. He has worked closely with the chief financial officer, who is Mass Mutual's key rating service liaison.

Mr. David W. Carlson: As Jack indicated, my remarks will address Mass Mutual's approach to the rating process. I'll start out with our perspective, which I think is quite important to make clear up front, given that we're not actually in the health business. I'll spend a minute on that, and then the bulk of my remarks will deal with Mass Mutual's approach to the rating process. Some of what I'll say will be similar to what Cindy covered in terms of Anthem's approach but, given that we're not in the health business, you'll see some different insights and a little bit more nuts and bolts in terms of just how we work the process. Then I'll discuss some of the specific measures from the perspective of a non-health insurance company. Then I'll finish up with a quick case study. This M&A story relates to our divestiture of our group health and life business just over a year ago.

In terms of perspective, it's important to get on the table up front that Mass Mutual now has a relatively small health insurance business. We used to have a relatively substantial group medical operation, primarily indemnity medical business but, as many of you may be aware, we exited that business just over a year ago now when we sold it to Wellpoint. We do have a modest size individual disability income (DI) business but, in the context of Mass Mutual as a whole, this business is actually quite small. It's about 4% of statutory revenues, and from an economic revenue point of view, given that downstream money management business has become a bigger and bigger part of the Mass Mutual enterprise, DI is even actually quite a bit smaller than the 4% suggests. So the bottom line is, Mass Mutual really isn't that much into health insurance at all.

Given that sort of profile, you might wonder what I have to add to a session dealing with rating agencies and health insurance companies. I want to give you the perspective of a company that, for quite some time now, has taken the rating

process quite seriously. We're quite proactive all the way around in the way we approach it, and even though it won't be health care specific, there'll be something in our comments or our approach to the rating agencies that'll be useful for people in the health business.

One other thing in terms of our perspective, is the rationale behind this proactive orientation. Mass Mutual is driven largely by the idea that in our core insurance businesses, real and perceived financial strength is critical to succeeding in those markets. You hear the rating agencies talk all the time about real, long-term sustainable competitive advantages. Our strategic vision is driven by the view that in those core insurance markets, demonstrated financial strength is, in fact, going to provide the sort of sustainable competitive advantage that, again, the rating agencies like. You see this throughout our strategic framework, and it really starts right at the top with the vision statement for the company, which is quite a clear and crisp statement that the company will be one of indisputable financial strength.

Obviously, there's more to financial strength than ratings, but for the marketplace, ratings provide a relatively objective way of differentiating between companies on the basis of financial strength, and we actually use them for some of our internal performance measures. It gives us a way of quantifying how the marketplace is going to look at us from a financial strength point of view. So you'll find, for example, in some of our incentive plans that actual ratings don't necessarily matter, but our relative ratings position compared to the rest of the insurance industry is actually built into our incentive measures.

Turning to some of the nuts and bolts of the process itself at Mass Mutual, our proactive management of the process translates into significant time, energy and resources being devoted to it. The driver of that process is the idea of constant, open, ongoing communication with the agencies and being sure that those communications all tie back to the strategic context that we talk with them about each year. We spend a lot of time making sure that all of our communications again tie back or link back in one way or another to the strategic context. And the last point here is that the process is also driven by this notion of the analyst as an insider, trying to do everything we can to avoid surprises. On both scores it's a little hard to take these concepts too far. Clearly, the analyst isn't an insider, and we constantly have a tough line to walk in terms of how far to push that idea given that there are certain things that the analysts and the agencies would certainly like for us to bring them in sooner, but we don't think it's appropriate. So, we constantly have tension between trying to truly treat them as an insider and the fact that, again, they really aren't. The same applies to the no-surprises objective. No matter how hard you try, there are always going to be situations that we run into where the analysts come upon something that we didn't completely prepare them for.

In terms of the team at Mass Mutual, as you might guess, given the proactive orientation, it's a fairly senior team all the way around. The liaison function that both Jack and Cindy talked quite a bit about should be handled by people who handle the liaison function well. We have an individual in that role at Mass Mutual who has been at the company over 20 years. She happens to be an actuary but hasn't been doing actuarial work for a long time. She has deep experience in a number of financial, marketing, and investment areas, and she really runs the show in terms of the interaction with the agencies. That's crucial, I think, in part for making sure that Mass Mutual's process is well-defined, but especially when the agencies come to us. It's important for them to have one person to go to and know that person is going to be responsive.

From our point of view, we know that part of what she's charged with is making sure that all of our responses tie back in one way or another to this strategic context. The CFO and the CIO for Mass Mutual both get actively involved in the process. They're involved in virtually every presentation and take a very hands-on approach to shaping the story and making sure that the process works the way that it should. And, as you'd guess, there are other senior presenters that get involved in the annual reviews. The heads of each of the company's business units make strategic presentations, and others get involved as necessary.

On the subject of the presentation documents, this may seem like a detail, although I was glad to hear Jack say that the agencies actually differentiate between those that are well organized and those that aren't. Some of us think, frankly, we beat this to death, but the people that actually go in front of the agencies come back time and time again and say that they're impressed by the quality of the presentation. Again, given the time and effort that goes into them, it's good to hear that's a point of differentiation on the agency's part. In terms of the specific documents that we use, they're professionally designed and put together. Probably most importantly the aim is to, again, tie them back to the strategic context point with a clearly articulated, thoughtful story and make sure that all the information that we want to convey is put into that story.

We spend a lot of time scrubbing the data to make sure that there's no surprises there, no embarrassments, and we use detailed appendices in our documents. I'm not quite sure how other companies handle this, but we want to avoid cluttering the main story with too much detail. Yet as the analysts ask questions in the presentations or, more importantly I think, as they go back and look at the books after we're gone, we want to make sure that they have the detail but, almost as important, we want to make sure they have the detail that we want to give them rather than leading them into other areas.

Sample Agenda for Ratings Presentation Meeting

1. Strategic Overview
2. Corporate Operational Overview
3. Compliance
4. Distribution
5. Business Unit Issues/Strategies
6. Investment Management Issues/Strategies
   - Portfolio review
   - Investment subsidiaries
7. Corporate Financial Review

This lists all the items on our sample service presentation agenda, but you can see in this particular case that we start with a strategic overview and with the hard-hitting corporate financial story. In between, we have a variety of issues, although the key ones really are five and six here, and I've compressed those a bit. The business unit strategic stories, and then in our case, again being primarily a life insurance company and a money manager, the investment-management operation is a huge part of the story. Those two items really get the bulk of the attention, other than the strategic overview and the total corporate financial picture.

In terms of the timing of our meetings with the agencies, the annual review is obviously a significant focus. Soon after year-end results are available each January, we put together a special-purpose presentation and we actually go see each one of the agencies in late January or early February. The idea there is to show them how we did relative to plan, to be able to characterize the numbers as literally hot off the presses and to show them that we're really trying to communicate quickly with them. And maybe, most importantly, it gives us a chance to tell them what we think is important about the results before they are actually published. So that at the late January, or early February meeting, although it's much briefer than the annual review and doesn't really get into the strategic discussion, it is probably one of the most important parts of the interaction from our point of view.

Then we've done special-purpose presentations over the years. A couple years ago S&P, for example, was quite interested to understand the dynamics of the DI market, given the problems that were emerging then, and notwithstanding my comments before that, it's not really a big part of our business. We're not sure why they came to us, but they asked us to tell them about the DI market. So we put together a presentation on that, and more recently, we've done one on our mortgage-backed portfolio which, as Jack suggested, has been a point of focus in recent times. My last point really ties back to something I've said before, and Cindy also touched on the idea of giving them advance communication on anything important or critical. They don't want to read about stuff in the newspapers. They

want to know that we're trying to bring them into the loop before it would actually hit the public. As I said before, though, this is a difficult line to walk all the way around you must have brought them in at the right point— and the point where we can get everybody at Mass Mutual on board to talk about certain sensitive issues. There's just a natural tension there to which there's no right answer.

In terms of our results, you can see here that we had the top rating from three of the four major agencies. A.M. Best, S&P, and Duff & Phelps; and for Moody's we're one notch below the top at AA1. The S&P AAA we think is a particularly good indication of how our process has worked. We actually got downgraded by S&P in late 1991, along with a large part of the insurance industry at that point. In the aftermath of Executive Life and Mutual Benefit and the continuing real estate market difficulties, a lot of companies were downgraded in 1991. We actually got our AAA back two-and-a-half years later, and given that there's a lot of inertia behind a ratings change once it goes into effect, the agencies clearly don't want to be viewed as vacillating. They don't want to be viewed as taking downgrades lightly. So, once they move a company down, no one's ever told us this, but our strong sense is that it's very difficult to get them to think hard about reversing that action. The fact is that after two-and-a-half years of hard-hitting presentations trying to show them why we thought they were wrong when we were downgraded, we actually got the AAA back in mid-1994.

Another example of what we consider to be a success in our process came at the conclusion of the merger with Connecticut Mutual, which started in the mid-1995 and was actually put in place at the start of 1996. During the process of the merger we actually met with the four major agencies a total of 20 times. That started before it was actually announced within the companies, so that the four major agencies knew what was up before 98% of the employee population knew that we were doing it. That continued all the way through—the process of the two companies evaluating the feasibility of the merger. The key thing there is that going into the merger, Mass Mutual's ratings were substantially higher than Connecticut Mutual's across the board. In one case, Mass Mutual's ratings were four notches above, and they were either two or three notches above the other three agencies.

After taking the agencies through the rationale for the presentation we kept them informed at every stage on how the strategic and business plan that we were putting together for the merged company looked. Once we'd taken them through all that, the old Mass Mutual ratings would apply to the merged entity we considered, again, would be a real success in terms of our ability to get our story across.

Turning to a quick case study, this relates to the sale of our group life and health business. This transaction actually occurred in two steps that played out over the

course of a two-year period, from 1994 to 1996. We moved the business out of the parent company into a stock subsidiary at the end of 1994. Then again, as most of you may be aware, we sold that business or sold the stock subsidiary into which we'd moved the business at the very beginning of 1996, with the transaction closing at the end of the first quarter of 1996.

The first discussions we had with the agencies, that started to hint to them that divestiture was on our options list, was in 1994, just as we were getting started on the process of spinning the business out. At that time all we were really doing is showing them that we had a lot of options as to how we thought we might deal with the health business. Divestiture showed up on the list for all the agencies in early 1994. We started a dialogue at that point, and I'm sure all of you are more in tune with this than I am, when the health care reform movement was still a fairly hot topic. We felt compelled, in light of that, to tell them what we were thinking strategically in terms of our group health business.

As our strategic direction by that point had started to move decidedly in the direction of the life insurance and money management businesses, we then took the step of confessing that this big entity we had as part of the corporate family wasn't, in fact, core to where we saw ourselves going, and that we were going to start looking at divestiture options. That would have been a tough step to take, but in the context of a strategic story that said we had bunch of options, and this business doesn't seem to be core to us anymore, the story actually worked quite well from our point of view. What was driving it to some extent was that we had made a decision that we weren't going to be in a position to commit any more capital to that business. It seemed clear to us that if you were going to continue to be a player, no matter how health care reform played out, that substantial capital requirements were going to be required somewhere along the way.

We also began showing them macro-level financial scenarios that tried to show what we thought the company would look like absent life and health business. Our group life and health business was actually quite profitable and was generating a fairly substantial portion of the total company earnings. So we felt compelled in talking about this particular option to show them what the company would look like with those earnings removed and what we might do with the sale proceeds in terms of growing our core businesses.

When the actual transaction occurred, we had all of this previewing of our options and what we might do put us in the position of being able to characterize the transaction as a sort of seamless continuation of the story that we'd been telling them for two years. Again we told them two years before it happened that our

strategic options included divestiture, and once again we'd made clear that we didn't view it as a core business.

This is a good example of advance notice being in the eye of the beholder. We actually signed the definitive agreement with Wellpoint on a Friday, and the public announcement was scheduled for Monday. This was the first week in January 1996. There was a huge snowstorm on the East Coast that Monday, so nobody did anything that day, and we ended up with the public announcement on Tuesday. So our view was that we had given them three days notice, and nobody else in the world knew it. We felt quite good about it. We had two different analysts quite bent out of shape that we had not brought them into the discussions earlier than that. That's just a difficult line to walk all the way around in terms of how much you share with people and when.

From Cindy's remarks it sounds as though in one of their divestiture transactions they had, in fact, kept the analysts more informed on how the shopping process and how the negotiations were going. In our case, one eye-opening thing that came to us when we actually announced this was that the analysts' view of what advance notice was ended up being a little bit different than ours. We also showed them at that point the financial details of what the transaction did, and again this fit quite nicely into the story we'd been telling them for the previous two years.

To summarize very quickly, you can see that our approach to the rating agencies really stems from our overall strategic process. I think it's important to note, though, that we don't view that process as a static one. With so much change in the insurance industry and financial services, our strategy is going to evolve. As Cindy said, strategies aren't a static process. You don't put one in place and follow it for 20 years. Ours are clearly going to evolve given the rapid change in the financial services industry, and we expect that our approach to the agencies will have to evolve in order to stay in touch with the overall strategies.