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Writing Long-Term Care in a Short-Term World

Track: Long-Term Care

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Summary: The theme of this session is the challenge that many insurers face as they try to grow their long-term-care (LTC) insurance business, while simultaneously ensuring analysts and shareholders that earnings targets will be met.

MR. MICHAEL S. ABROE: We have panelists starting with Eric Berg at Lehman Brothers. He's going to be participating by phone. He wasn't able to leave New York, but we're still glad that he's able to participate. Eric is the managing director and head of insurance research for Lehman Brothers. Next we have Julie Burke with Fitch Ratings, where she's managing director. Both Julie and Eric will be discussing long-term care from Wall Street analysts' viewpoints. Next we have Paul Forte from John Hancock Financial Services. Paul is second vice president and product manager on the group life and long-term-care side of John Hancock. Then we have Sue Morisato, from Bankers Life & Casualty Co. She's senior VP and actuary at Bankers and is directly involved in all the long-term-care business and all other lines that Bankers offers.

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

The format that we're going to follow today is a Q&A format. There's a series of questions that we're going to ask and get the analysts' and industry's perspectives on the questions.

The first question is geared to the analysts. Long-term-care insurance (LTCI) is still considered an immature industry. What are the risks of long-term-care insurance in the view of the analysts? How is LTCI perceived by Wall Street? What are your concerns?

MS. JULIE A. BURKE: With regard to some of the risks we see, from the credit analysts' perspective, I guess there are a number of them. First, the obvious one is claim risk, and that means frequency, severity, and timing. There's not a lot of history to work with. Growth has been fairly rapid, with a very long period between policyholder issue and claims, so a lot can happen. I think we would all agree that some of the older policies used less rigorous underwriting, so there's been some adverse experience with regard to cognitive claims. Medical advances in technology could impact future claim experience for better or for worse, and so we think the biggest threat is under-estimating utilization.

Another risk we see is lapse risk. Persistency is certainly a double-edged sword. But on the positive side, good persistency means there will be a longer period over which to amortize costs, as well as to build a block of business. On the negative side, the people that lapse tend to be the healthier people, so there's some anti-selection.

We see expense risk. You certainly need to build an infrastructure and manage it efficiently, and you certainly need a critical mass of policies in place.

There's interest-rate risk because of the long period before claim payout. There's also regulatory risk. We think there's increased regulatory scrutiny. I think long-term care has been riding below the radar screen for a long time, and that's probably no longer the case. Companies are very concerned as to whether regulators will approve price hikes. We do see some market conduct risk. Whenever you have high or significant price hikes, that tends to open some eyes, and I think some of these policies were sold for better or worse as level-premium policies.

We think some of the things that can mitigate risk are training and monitoring of agents, a strong code of ethics, good customer service, and goal underwriting. We also think that maybe there's a little bit of government risk, with regard to what the government's role is going to be going forward. Will they encourage the private funding of long-term-care needs? What is tax policy going forward? What is the future role of Medicare and Medicaid with this product?

Then finally, I think we see general-business risk. It is a competitive environment. There has already been a shakeout with several of the large players exiting and other blocks of business for sale, so I think we can certainly expect more

consolidation.

MR. ERIC N. BERG: The fact of the matter is the risks of the long-term-care business, at least as perceived by the analysts, are very different from the risks that are perceived by Wall Street. The reason is that, quite frankly, Wall Street—and by Wall Street, I mean professional investors who are my customers—have, in my mind, a surprisingly low knowledge of what the long-term-care business is all about. It's hard not to know that the business is out there. Hardly a month passes, it seems, that some major news publication is not talking about the need for long-term-care insurance and the challenges of providing long-term care. So everyone in the investment community is aware of this big, beckoning industry called long-term care, if only because everyone knows an older person who has long-term care needs. I have been struck by how the knowledge really stops there. Many of my customers still think of long-term-care insurance as just nursing home insurance—even though we all know that the industry has advanced dramatically in recent years, to the point that contracts today cover home-health care, and I gather that some of the contracts cover care even by family members.

So my first point is that the risks, as perceived by Wall Street investors, are quite minimal, because their knowledge of the industry is minimal. When you get to people such as myself, who think about the business full time—or at least the life-insurance business full time, of which this is one corner—obviously, our knowledge is greater. We see, therefore, more risks than the typical investor. I'm not one of those who believes, as some people do, that morbidity risk, in general, is a bad thing. I think, like any risk, it has to be understood, measured, and managed. But I do believe, based on conversations with others, that we are, to a certain extent, in the early days of gathering data, particularly on recently-issued contracts. That is to say that a lot of the contracts are of a fairly-recent vintage as well, because contract language has changed a lot in recent years. The experience with new types of contracts—and not only are there a lot of new contracts, but there's a lot of new contract language on the books, for which experience is limited. I worry about the retention-risk issue from our work with all sorts of companies, from Hancock to Conseco and others.

I sense that there is—or at least there has been—a nationwide problem, with respect to too much customer retention. That's kind of a curious thing, because in most businesses, having too many customers is obviously a good thing. And then, of course, I worry about cognitive impairment. I'm not sure whether the incidence of Alzheimer's disease in the country is growing. Certainly we are more aware of it. I know, from first-hand experience in my own family, as well as the experience of friends, that insurers' fears are absolutely well founded. That is mainly because Alzheimer's is the type of illness that is not only terribly costly to care for, but one of the easiest to hide.

So in summary, in terms of risk, I worry about contract language, this issue of too many people holding on to their contracts, and insurers' ability to detect and shield

themselves from the anti-selection associated with cognitive impairment.

Also, I have been struck by how many investors somehow tie long-term-care insurance to disability insurance, as if the two are the same. I know they're not. We're not dealing with open-ended coverage here. You don't have nearly the same risks as moral hazard. But in my experience, the industry has a very big education job on its hands, because there are still many investors in this world who tend to think of the two as very closely related, if not very similar.

MS. BURKE: I think one of the things, from a credit perspective that we're always concerned about is a red-flag situation. Beware of companies that grow too rapidly in any line of business, and that includes long-term care. So to the extent that growth is moderate, I think we feel a little more comfortable, particularly because of all of the uncertainties that we've already mentioned. So we do get concerned when we see companies growing too fast, or when we see long-term care becoming too big of a piece of the overall pie of a company.

MR. ABROE: Let's move on to question number two. This again is for the analysts. Are analysts' expectations being met? What do the companies need to demonstrate to meet analysts' expectations?

MS. BURKE: When we develop expectations for ratings, we develop expectations for the overall performance. The expectations tend to be based on the company's expectations, our understanding of the markets they're in, and also the competitive environment. We're always comparing expectations to actual performance, so to the extent that the company can meet expectations year-after-year and build a track record, that gives us some confidence in management.

I can't say if the industry as a whole is meeting or missing expectations. As you know, performance has varied quite a bit among companies, so we tend to look at it more on a company-by-company basis. What's interesting is that we do talk to some companies that have made a conscious choice either not to offer this product, or if they offer it, to offer it at very non-competitive prices. What they say is, we know this is a product that's great for our distribution, and we know there's a need in the market place, but we look at it time and time again, and we just can't make the numbers work. So that's kind of an interesting perspective for a rating agency to hear. The couple of companies that I'm thinking about who have said this have pretty solid management teams and are fairly conservative.

To date, we haven't changed any ratings because of the performance of long-term care. For most of the companies we rate, it really represents a pretty small portion of their overall business. So to the extent there have been issues within long-term care, they haven't been big enough to affect the overall company rating.

MR. BERG: I don't have much to add to what Julie said. One important difference between her world and mine is that you often become a corporate insider and have

access to non-public material information, whereas we don't, and I'll get into this a little bit later in another question. For all of the publicly traded companies, there is no one who has such a large long-term-care business that better-than-expected results or poorer-than-expected results would matter in a big way.

Probably the most visible players in the publicly traded world would be the Conseco companies and John Hancock. In both of these instances, long-term-care insurance is one activity among several that they do. I would venture to say that in Conseco's case, it is not the flagship business. A flagship business would be, probably, the annuity business and the consumer-finance business. In John Hancock's case, it is, above all, a life insurer. So as to whether expectations are being met, it's sort of hard to tell, because businesses are relatively small in the scheme of things. From the limited information available. My sense is that, in general, expectations are being met. There has been accelerated amortization of deferred-acquisition-cost (DAC) expenses. Most typically for persistency reasons, companies have written off DAC at an accelerated pace. There have been periodic claims issues. I recall that, maybe three or four years back, one of the Conseco companies had an issue in south Florida, where there was an issue around questionable claims. It is my overall sense that, in general, these businesses have been performing in line with the management's expectations.

MR. ABROE: We'll go on to question three, which again is for the analysts. What information are you getting? How much variability of information is there by insurer? For example, in what areas do insurers need to improve? What information or demonstrations do you want that you're not getting?

MR. BERG: My answer will be blunt, but hopefully to the point. The disclosure is really bad. It's not particularly helpful. As Wall Street analysts, as securities analysts, we're in the business of measuring corporate performance. That means not just revenues but expenses and, in particular, profit as well. So the best that I can tell, there is no company that I follow that reports on its results—that disaggregates the results of its long-term-care business. Data on sales alone is not particularly helpful. It's one data point, but it's not particularly helpful. Data that gives sales or premiums for the long-term-care area, but that aggregates benefits, paid claims, and changes of reserves across all product lines, so that it's impossible to know how the long-term-care line is doing on a GAAP basis, is not helpful.

I have to review things. I believe John Hancock has a stand-alone, long-term-care income statement in its financial supplement. They may be the only one. In general, there's got to be more disclosure.

MS. BURKE: As Eric mentioned earlier, we probably have access to a little better information, because we are considered insiders. We don't really have a formal checklist or survey that we ask companies to provide. We're really interested in seeing the tools that management uses to manage the business. So to understand the internal-reporting function, some of the things we ask the management of long-

term-care divisions are: What does your senior management use to determine your performance? How did you get your senior management and your board of directors comfortable with this business, because it's obviously a risk business?

We often will receive copies of materials presented to senior execs or the board of directors. I guess if a company's doing rate increases, we really want to fully understand why that was necessary. If it's driven by a very specific problem and a very specific band of policies, we can perhaps feel comfortable that it's isolated and therefore not spread out to the whole organization.

We also try to understand what a company's going to do to prevent these issues in the future. If a rate increase is really broad-based, then it calls into question the initial assumptions that were made when the business was put on the books and/or the management of the business since it's been on the books. So we also look for reporting from companies along those lines.

From a statutory-reporting perspective, what rating agencies generally want to see is that statutory losses are fairly modest—that growth isn't too rapid—and that the company can finance these losses through earnings from other lines of business. You'll often see a mature product line supporting the growth or funding the growth of an immature product line that's generating statutory losses. That's one of the real benefits of diversification.

From a GAAP perspective, we're looking at an actual performance relative to expectations in the assumptions that were embedded in the pricing. What we're looking for is consistency year-to-year, without a lot of variability. So those are some of the things we tend to look at.

MR. ABROE: What are the risks for long-term care, as viewed by the industry?

MR. PAUL FORTE: Let me just start by saying that I hope that panel discussions like this one will go some way toward correcting the lack of information and understanding about this important and vital new industry. Long-term care is a risk business, but that's a good thing. I think the events of September 11 have shown us that there is a very important place for insurance companies in this country and in this economy. For someone who's been in it for twenty years, there have been times that I've wondered whether anybody really thought that. There are things that we do that mutual fund companies and investment companies generally do not. I think that, picking up on something that Eric said, morbidity is not necessarily a bad thing, if it's managed.

Now, having said that, I think there are some risks that we need to be concerned about. I'll just mention four of them and then invite Sue to add. They'll be familiar to people in this audience, I'm sure. They may not be exactly what investors or investor analysts think as the principal ones, but they include morbidity.

Morbidity assumptions, of course, could be wrong. Right now, the industry is largely seeing better-than-expected claims. I'm not sure that we've really figured out the natural course of every pathology that is capable of causing claims. Just a few short years ago, AIDS was causing a concern for LTC insurers. This is clearly not the case today. Some see the LTC risk in the future decreasing because of new drug therapies that are making their way into the market that will reduce the incidence of stroke, heart disease, and even Alzheimer's—a concern of Eric's. There are an awful lot on these inhibitors that are being developed and manufactured now by various drug companies that would seem to go well. We think about our horizon in ten, fifteen, twenty, and thirty years, and we're actually hopeful. On the other hand, some people think that LTC risk will increase because those who are in care will live longer in care than they do today.

The second thing is lapse. The industry as a whole initially estimated voluntary lapse to be a lot higher than it turned out to be. As we all know, once people buy LTC—and they don't buy it that easily—but once they buy it, they hold onto it. Most experts put the average lapse rate now at around 4 percent, with ultimate lapse rates at 2 percent or even 1 percent. This is, of course, markedly different from what many of us assumed in pricing our older blocks of business eight to 10 percent. Obviously not having people dropping the coverage means that you have to hold larger reserves than you thought you were going to need, because you have to have reserves on all active lives. On the other hand, lower lapse rates can help unit costs, as you will have more people over which you can spread your fixed costs, and you will have more time over which to amortize the original deferred-acquisition costs. So that's helpful.

Interest-rate risk is a big one, as the time payout for LTC claims is so far into the future for the individual business—12 to 15 years; for group—25 to 30 years. Interest rates are a driver because a line of business invests assets to back up reserves. These are mostly fixed-income investments with longer durations. But even a difference of a half of a percentage point on portfolio rates can make a huge difference over the long term. So many insurers try to hedge that a little bit by putting in a provision for adverse deviation, which they deduct from the interest rate required to form the reserves. The companies use that and hedging strategies, using derivatives, to try to eliminate volatility in interest rate earnings and to smooth out those earnings, so as to make results more predictable. Of course, hedging requires a lot of expertise. It isn't always successful. Mistakes can be costly.

The final thing is expense risk. Obviously, it could cost you a whole lot more to capture business, to put it on the books, to train your field force, and to build and develop the technology that you need to manage a business. If you've anticipated more premium over which to spread your costs than you're taking in, you have a problem. On the other hand, if expense is lower than you price for, you're going to see that profit drop right to the bottom line.

So those are the four risks that I think insurers tend to look at. When they're looking at reporting their quarterly earnings, they're looking at those four counters: morbidity, lapse, interest-rate performance, and expense. If they've got those, so that they're managing them, I think that a lot of the other concerns don't exactly disappear, but they are seen within a larger context that is not uncomfortable.

MS. SUSAN C. MORISATO: I think that Paul's right. The four prior risks are the ones that are listed. What I was going to add is that, when you look at morbidity risk, which is probably the biggest of the four, it's really influenced by the internal company's operation. Underwriting processes and claims management are probably two of the biggest things that can influence morbidity risk internally—particularly underwriting. I think that if you look at experience across companies, over the history of this product line, the underwriting process has been one of the things that has differentiated, to some degree, the value of a number of companies. Even within underwriting, the interesting thing that we've come across, as we look at other organizations—particularly since Conseco has been involved in some acquisition activity—is that several companies are likely to have fairly similar underwriting rules or criteria. People don't accept diabetics with insulin, or they don't accept people with cognitive impairments. The actual rules with which they will reject cases are fairly similar. The real key that you find, though, is how the companies actually get to the real health profile of that risk. Some companies will spend more time relying on the application, and others will spend more time doing face-to-face assessments or doctors' reports. The degree that you go after protective information can have a fairly large impact on your ability to actually execute the guidelines you've established. So you can have two companies with identical guidelines and with different protective information requirements and get very different results.

The same sort of difference occurs in the claims management area. The way you adjudicate and manage benefit eligibility and establish that criteria can also vary company-to-company and that can also affect the morbidity risk—besides all the external things that will affect morbidity going forward. There are some other issues that also get to the heart of claims or morbidity in a broader context, and they are field conduct and training.

One of the issues is that this form, at least on individual policies, is sold to a lot of elderly people. Policies for the elderly, in general, tend to be regulated more heavily and scrutinized more heavily by the state insurance departments on all fronts, and companies can find themselves in trouble when the agents don't behave in the appropriate manner. For example, they promise benefits that really aren't in the contract. The companies' results depend on whether or not they're going to be liable for those statements that were made early on at the point of sale. Environment, regulatory, and the industry itself can all change related to market conduct issues.

The last of this, from my perspective, is that one of the things that we've come to

believe in our company—probably because we're a long-term-health-insurance organization—is that long-term care, like any other health-insurance business, really can't be managed functionally and independently. The success of a long-term-care product really has to do with the full integration of all of the operating areas—understanding what each is doing. You can price the product with a certain set of notions and criteria, but if that's not being carried through in the operations perspective, your pricing might be right, but your support is not, or vice versa. As a result of this, the performance could very well not meet expectations—and not because the pricing per se was wrong, or the price design was wrong. It's that the integration is really critical to the success of managing the risk.

MR. ABROE: Let me move on to the next question. As companies become more creative with product-design features, what additional risks are being introduced? Is this a good thing for the business market?

MS. MORISATO: As a company that's actually been in this business since its early history, what I've noticed is that we, like other companies back in the early and mid-80s, started relatively conservatively. There were companies that misstepped, relative to pricing and underwriting, but in general, the companies were relatively conservative with the benefits that they provided and the prices that they charged. There were, typically, three-day hospitalization requirements, and those kinds of things offered a lot of gatekeepers that don't exist in contracts today. Over the intervening five to eight years, what we found is that the products got increasingly better, companies started to get a little bit more comfortable with the products, and as a result, the prices for benefits started to come down. People got more comfortable with the underwriting and the pricing, so as a result, some of the prices started to come down.

In the last five years, I've seen trends that actually concern me a little bit. What is happening is that the benefits are getting a bit more expansive. We are seeing more liberal benefits and more comprehensive benefits. I guess, on the positive note, this is probably the actual big advantage of the free-enterprise, independent-market system.

I think that there is some potential here for the market to swing too far the other way. My hypothesis is that the industry believes is that this is a huge-growth market. But if you actually look at the stats, while long-term-care sales have increased, I think some companies feel that they haven't seen the growth that they would have anticipated in a market that's totally under-penetrated, and that clearly seems to have the potential to be explosive.

The research has indicated is that there is a lack of consumer demand for this product. I mean, everybody here in this room thinks this is a great product. The consumer out there—through lack of understanding, lack of priorities, denial, and a whole host of other reasons—has not latched on to this product in the way we would have liked. As a result of that, the distribution, particularly on the

independent agent side, has been somewhat limited, because it's a tough product to sell. As a result of that, my theory, and I'm certainly open to some discussion, is that, as a result of that competition for distributors, companies who really have to attract the high producers are perhaps starting to liberalize benefits to attract those producers. It's not so much for the consumers but for the producers themselves.

While the dynamics are very different, it makes me wonder whether or not the long-term-care market may be following some of the actions of the disability-income (DI) market several years ago. They were all trying to go after the white-collar market, and there was a lot of re-definition of benefits, to try to attract the marketplace. I see that there's some potential here, in the long-term-care arena, for doing that. Financially, the dynamics are different, which I think will help the long-term-care market. But it does raise the question as to what the future will hold over the next several years.

MR. FORTE: To follow up on what Sue was saying, I think that, in general, these improved plans have been good for the market. I think consumers need to have some sense that they're getting something real for their money. Obviously those who are risk-averse don't need much persuasion, but those who aren't need something more tangible. I know this has certainly been the case in the group market, which I specialize in, because you're attracting people in our age group who are buying this and may not use it for a very long time to come.

I agree, however, with Sue. I think some of what we're seeing with product design has been driven by some prominent, relatively small, but highly influential minority of agents, who are working with the affluent. They're looking for a leg-up on the competition, and they've pushed product managers in times of lagging sales. We're seeing this especially in the last 18 months, with the slowdown in the economy—to do some things that maybe we're not altogether comfortable with. For example, there has been an increase in the number of policies that are being written with unlimited benefits or limited-pay options. You've got your premium, and you're not going to be able to make any changes to the rating structure.

Some people are worried about home-health care only and the potential for abuse, because there would seem to be no disincentive to using home-health benefits in the way that there is a disincentive to using nursing-home facilities or even, for that matter, assisted living. So I think you've got that as an issue.

Also of concern is the push by regulators for rate stabilization. I think that that will be of greater concern to those companies that have driven hard to acquire market share, have used more liberal underwriting, and have gone after questionable risks to grow their businesses. I think it's a greater concern for them than it is for companies that have consistently practiced a fairly responsible and rigorous underwriting and, as Sue said, have had the good sense to integrate their businesses, so that their pricing people and the people who are actually doing the underwriting, claims adjudication, and care management are working together in a

tightly knit group, sharing insights as they arise. It's possible that we will see some additional risk-based-capital (RBC) requirements if we start to sense that maybe there is some under-reserving. So liberalization of benefits may not be without its risks.

In general, I'm not overly concerned, and I'm certainly not concerned that this market is over-stated in its potential, because I still don't see a viable alternative. Yesterday morning in session 60PD, Mark Litow was talking about expenditures, and I think he cited a figure, a national overall health-care expense cost in 2000, of $1.2 trillion. His estimate on long-term care was $177 billion. I don't know where that comes from, if not from private long-term-care insurance. The fact that the federal government is hard at work, trying to put together its program—which will be effective in October 2002 and will be made eligible to some 20 million people, including many of the nation's most influential legislators and executives—is going to be a powerful stimulus to this market. So the train hasn't quite reached the station, but it's coming. I think the wall of denial is starting to crumble.

MS. BURKE: I was interested in Sue's comments. It seems like all products have this life cycle, and long-term care, it seems, has the same life cycle. I think back to a product like variable annuities, where five or six years ago everyone was selling plain-vanilla products with plain-vanilla death benefits. The market got bigger, and players became more aggressive and started putting in very aggressive death benefits—aggressive guaranteed income. There were stock market crashes, and now they're all kind of licking their wounds. So it seems like this is consistent. I think you also saw a similar cycle with the disability income. So it seems that most products tend to have the ebbs and flows as they mature.

MR. BERG: I agree with that pretty much. There is product creep throughout this business. Features get added, underwriting gets liberalized, and tests get waived. The marketing people take control of the process. I think that there are too many instances in which the "agents" are not really agents of the company, but rather are representing uniquely the interests of the customers allowing them to sidestep the underwriting process. Somehow, companies need to do a better job of aligning their interests with those of the producers.

MR. FORTE: There's only one point I'd like to add. It goes with something that Sue said about policies getting less expensive with comparable benefits. I think that is largely true. There are some instances, particularly in the group market, where efficiency is derived from the use of the Internet, and other technologies have allowed the group carriers to reduce their expenses considerably. Especially in the all-important area of enrollment, we've been able to liberalize some of our benefits without necessarily cutting into margins, because we're seeing some very attractive expense savings.

MR. ABROE: Why should insurers be in this business if it has negative statutory cash flow for the first four to five years, or even longer?

MR. FORTE: I think the points are pretty straightforward. Many businesses require some kind of an outlay, and not all of them are as attractive or strategic as long-term-care insurance. You don't have to set up the statutory reserves until the end of the second year. The bulk of your up-front expenses are deferrable for GAAP-accounting purposes, and I think for stock companies, that's really what the focus should be. Persistency, as we all agree, is very high, so that may be a bad thing, because we have to hold more reserves. But it's a good thing insofar as there's a stronger likelihood that we'll be able to recover our expenses, and we have a longer period over which to recover them.

I'll just mention that, with respect to group plans, that they have an added advantage in that they can take in new enrollments at virtually no cost. People can just decide at virtually any time, through visiting a Web site, to enroll on line. All of the information is electronic, and so you have considerable savings there. Then, of course, the administration is done through payroll deduction. You handle inflation additions the same way. So these are offered, and they can be offered without going out to market in a competitive bid. They require relatively little marketing support. You can even do upgrade offers in the same way, and some of these upgrade offers have been quite successful.

In sum, I would say that maybe the question is not so much one of statutory strain, as what kind of GAAP earnings are you expecting to generate? How predictable will they will be? And what kind of growth in earnings can people expect?

MS. MORISATO: I don't have a whole lot to add here. I agree with Paul. There are a lot of businesses that obviously have strain. Recognize that this is a growth business. If you have a fairly sizeable book, as we do that we've been successful with, it's almost a question of how can we not be in this business at this point given the demographics? We do focus more on GAAP earnings, to the extent that we have enough cash flow to support the statutory strain, which is somewhat of an issue. It's really a matter of being able to just manage both sides of that account.

MR. FORTE: There are baby boomers who are seeking to have a more comfortable and secure retirement than did their parents. Aging people are going to need LTC services. These services are expensive. Insurance is still the best way to finance them. LTC completes a marketing portfolio. It's a means by which you can help people to cover what could be the greatest unfunded liability of their lives. Regulation is now tougher, but as I said earlier, on the whole, I think it's going to be favorable to responsible insurers. If you know that you have to adopt a very responsible approach with respect to pricing, and that those prices are going to have to stay stable indefinitely, you are not going to be engaging in low balling, liberal underwriting, and misrepresentation of benefits.

Morbidity is likely to improve. I believe, from everything I've read, that we're going to see improvements and that policy premiums can be increased. This is important. You can file for increases. That's something that you really don't have on the whole-

life side. Reserves can be substantial. These are some of the reasons that I think it makes sense to be in this business.

MR. ABROE: Question number eight is about rate increases. What do they measure? What do they tell us about the strength of a company or the value of a block of business?

MS. MORISATO: I guess the short answer is that it may not tell you much of anything. Taken in isolation, a company that's chosen to take a rate increase in and of itself may or may not be any indication of concern. You have to understand why that's occurring. If it's isolated—if it's across the board and from an outsider looking in, what you'd probably be looking at is comparative rate increases, and a history of rate increases. A company that does have a pattern of rate increases is certainly a clear indicator that there's an underlying problem. But in the end, it really has to do with understanding the makeup of that organization—whether or not they have pricing, underwriting, and claims departments that are working together, or if there are underlying operational issues within the organization. On the other hand, the companies who have not had rate increases historically are not necessarily healthy books of business.

It may be something that's just waiting to happen. We do know that carriers, if they're big enough and know that they may need rate relief on their in-force book, may try to grow their way out of it with new products and new prices. I think that while rate increases can be indicators of a company's strength or value in and of themselves, it doesn't necessarily mean a company has problems. If a company has an insolated rate increase, it may have taken care of a problem, and it may have been very conservative in doing that. Clearly, going forward, taking rate increases is going to create a lot more stigma than it has historically because of the new NAIC regulation, so that will create different kinds of dynamics in the marketplace going forward.

MR. BERG: Looking at it as a professional student of companies, trying to evaluate them from an earnings-growth perspective as opposed to a credit perspective, isn't a matter of degree. Certainly we understand that morbidity risk is, by its nature, less measurable and less predictable than life-insurance risk. Surely that is the case, but that's what actuaries are paid to do, and they're trained to do it over time. I would think that, just as in the disability business, it would be troubling to me, as an equity analyst, if a company was constantly filing for rate increases and was unable to get it right. The new legislation that, I gather, is going to take effect the first of the year, is really aimed at stifling lowballing by repeated offenders. From an equity analyst's perspective, that is where a company would get into trouble, if it is repeatedly missing the mark in terms of estimating morbidity costs and hitting customers with relentless bouts of 5, 10, and 15 percent price increases. What can you say about a company—other than bad things—that doesn't understand its cost of goods sold?

MS. BURKE: Rate increases, regardless of how necessary they are, do create PR problems. Obviously regulators aren't happy, the distribution that sold it isn't happy, and certainly the customer isn't happy.

MR. ABROE: How does a LTC regulatory and/or legislative environment affect long-term-care operations and/or earnings?

MS. MORISATO: Clearly, like most insurance contracts, there is an inner-loss ratio requirement. There is a certain level of benefits that must be provided to the policyholder. So in a very broad sense, that obviously constrains expenses and profits. Unless you're very efficient with your expense ratios, it is going to somehow define the profit that you can generate out of this business.

Perhaps the most notable regulation that's affected this industry recently is obviously the new NAIC model. It has some interesting dynamics in it. One is that actuaries will now be required to certify that the premiums that are being filed are adequate to withstand moderately adverse experience, which is something that's new and has not really existed in other lines of insurance. The jury's still out in terms of what that will mean relative to pricing. I understand there was a recent seminar that indicated that actuaries and companies might actually start to increase the price for their contingency for adverse experience. I guess, because I'm very heavily involved with our marketing organization and understand the pricing within our own contracts, my initial response is that I'll believe it when I see it. I just don't know what kind of real impact that will have on pricing for these products.

Having said that, there is a movement to try to understand the behavior of companies who do, as Eric said, have repeated rate-increase activities. So, while there are no prohibitions against rate increases in this new model, there are significant hoops to go through, should you decide to file a rate increase. You have a higher loss ratio requirement on the increased portion of the premium. Clearly, the move here is that they really want to prevent companies from, either intentionally or unintentionally, under-pricing products.

As Julie pointed out, there are going to be rate increase disclosures. So not only you, but all of the free world will know what your rate increases have been and will be going forward. I think all of those things are going to put pressure on industries to really do responsible pricing.

The news is not all bad. There is a recognition, continually, that long-term care in general is going to be a huge ticket item. And there are incentives out there on the federal side and even state side, relative to tax efforts to purchase long-term-care insurance. The above-line deduction will not pass this year for a whole variety of reasons, somewhat related to the events of 9/11. But I think the time will come where that will happen.

There are already state incentives that are out there. There is also the federal long-

term-care insurance program, which again legitimizes the long-term-care insurance markets. So the news, quite frankly, is not all bad. I think there are some positive tradeoffs here.

MR. FORTE: That federal program, Sue, may very well be an added incentive to legislators to get that above-the-line tax deduction passed some time next year, when the smoke clears.

MR. ABROE: Are return on investment (ROI) and return on equity (ROE) targets consistent with other insurance products? Considering the nature of LTCI risks, are ROI and ROE targets appropriate, given the level of such risks?

MR. FORTE: When we think about it, we think that perhaps LTC is best compared to whole life, but you've got some things that would suggest that the hurdle rate should be higher and some things that suggest that perhaps the hurdle rate should be lower. You've got a large amount of capital that's tied up in marketing expenses. This isn't really capital. There is economic capital at risk. You know you're going to recover that within a few short years of the policy. The policies are highly persistent. You would think that maybe that should take the hurdle rate down a peg, because you don't have as much capital at risk.

At the same time, we know that the insurer can raise rates. It's true that the new NAIC model rates are going to make things tougher for insurers for all the reasons that Sue has said. But the theoretical ability to raise rates, particularly for deviations way outside of the expected norm in morbidity, is going to be there. Whether there will be any tolerance for such things as lapses, adjustments to the lapse rates, I doubt it. They have been granted in the past, but I don't think that we'll see that going forward.

Another positive thing is that long-term-care claims, unlike DI, are not really tied to the economy. There is no incentive in bad economic times to file a claim on your long-term-care policy, and you do have to be activities of daily living (ADL)-certified as either ADL-dependent or cognitively impaired. At the same time, they're not cyclical, which is what you see in other lines of coverage, particularly the health business.

Now, going the other way, and maybe pushing up the hurdle rate, is that most of that premium must go into active life reserves. Maybe not in the first year, because that's when you're going to take your hit for your expenses, but in the second and subsequent years, you have to put a huge amount into your active life reserves, which causes surplus strain. That surplus strain has to be offset by something. Hence, the hurdle rate goes up.

Then, of course, there's morbidity. The fact is that we do not yet, in spite of the talented people in this field, have this pegged. If we did, all we'd really be doing is competing on expense and administrative efficiency and customer service. Clearly

this is still a risk business. There will be winners and losers, and that hurdle rate needs to reflect the risks that companies are taking.

MS. MORISATO: Paul did this comparison on life insurance, and I guess my only observation is that when you look at this from the health-insurance perspective, one has to be a bit careful. What we discovered in our own organization is that if we were to strictly look at our live targets—because the strain is fairly low in the first year, and because, as a career-oriented agent system, our renewal compensation levels are also not that high—we could actually get fairly significant ROIs, with profit margins that really might not be all that high. It turns out, for us, that looking at percent of premium pretax margins is actually a better indicator of our profitability than looking at an ROI. We are starting to look at ROE targets specifically by line of business. It's not something historically that we have done. I think that would be a good measure of profitability in the long run, but I think that for long-term-care insurance, depending upon the actual cash flow for your organization, it's important to look at several profit objectives, as opposed to just focusing in on one of them.

MS. BURKE: Generally, companies price products to achieve somewhere between a 13 to 16 percent ROE. Obviously, mutual companies, those that are left, price to more modest targets. Typically, when companies look at the E component, in terms of how they price these things, they look at a multiple of NAIC risk-based capital. Since RBC is a risk-adjusted measure by definition, pricing is risk-adjusted. That, of course, assumes that the NAIC has the right risk charges, and I think that's up for debate.

I would say most companies that we talk to price products somewhere around a 200 percent RBC capital charge, and companies generally carry significantly higher risk-based capital levels than that, so they're earning investment yield on their unallocated surplus.

MR. BERG: I agree with what Julie said, that companies, in my experience, use a common hurdle for many of their products. I think Julie said 13 to 16 percent, which is what I have heard over the years. I have heard insurers say that we price our long-term-care business to, say, a 15 percent return. No one has ever explained to me why it's 15 percent. I find it curious—perhaps puzzling is a better word—that interest rates have been all over the map in the decade of the 1990s. They're now at the lowest level in my lifetime—over 40 years—and yet benchmark rates haven't changed. So I would say that yes, ROI and ROE targets are consistent with other insurance products. That makes no sense to me. Maybe it should, but no one has ever come forward to me with analysts saying, "We studied the risk, given the risk-free rate, i.e., the rates of interest in the economy, and given the risks inherent in the long-term-care business,, the rates on investment and the rates on equity are appropriate." I really have no idea whether it's appropriate or not. No one has ever presented me with analysis to that effect.

MR. ABROE: Just as a personal follow up, Eric, I take it by your comments that

you're expecting that the yields for companies in long-term care are likely to go down because of current interest rates.

MR. BERG: Well shouldn't everyone? Doesn't basic financial theory suggest that the declining interest-rate environment means that all risk-adjusted rates of return should come down? Let me say, more broadly, that it's very hard for us analysts to know really truly what's going on in this long-term-care area, because not only is it true, as I mentioned earlier, that more often than not, we do not get disaggregated income statements by that line of business—but we don't get a balance sheet, so lots of things could be going on. Companies could be losing their shirts, and we wouldn't know it, because we don't have the income statement. Companies could be making lots of money, but the return could be miserable, because of the capital tied up in the business. Until we have the GAAP information to do basic financial analysis, I really can't opine intelligently on the health of the business.

MR. ABROE: Question 11, how consistent or inconsistent have ROE targets and ROE experience been for the LTC industry? How does that compare by company, by reporting period, between companies?

MS. BURKE: I think, with a long-tail line like long-term care, it's important to look at financial performance over a long period of time. Therefore, I guess we don't gain a lot of comfort by seeing a year or two or three of good results. If you put too much weight in your short-term performance, you can get fooled. It's kind of like the long-tail property and casualty (P&C) companies that generate these great combined ratios for five years, and then they take a $400 million reserve hit. That basically means all those earnings they reported in the last five years were overstated. I think that's one important thing to keep in mind with regard to the long-term-care product. It is a very long-tail product, so we really have to look at long-term performance. And the business isn't mature enough, at this point, to really make a good case either way.

MR. BERG: The only thing I could add is that, if this were proving to be a disaster, at least near-term for some company, we'd probably hear about it. There's no incident that stands out in my mind of a company running far field of its ROE target. Of course, as Julie said, it's early days.

MR. ABROE: Is there a perception that LTC won't have some catastrophic or non-predictable events affecting the delivery of LTC services? Is such an event likely to catch insurers by surprise? How should an insurer address this issue and present it to the investment community?

MS. BURKE: I think there is a perception that long-term care has risks inherent, for all the reasons that we've already talked about. Whenever you have a long period of time between policy issue and claim, a lot could happen that is both predictable and not predictable. When you look at the rapid development of medical science, it's really difficult to foresee five years out, let alone 20 years out. We've talked about a

cure for Alzheimer's. What about genetic testing? I think back when AIDS exploded on the scene in the mid- to late-'80s; the early thought for the life insurance industry was that this was going to be catastrophic. It became quite the opposite, because the blood screening that was put in place to screen for AIDS actually gave underwriters a lot of very good information in addition to that—like tobacco use, drug use, cholesterol, and things. The risk assessment information was much better post-AIDS emerging. If you had told someone that in the mid- to late-'80s, they would never have believed you. I think that is an issue.

There is a legacy issue with regard to DI. I think there is a bit of a legacy as to what DI is that we all talked about, at least with perceptions among individuals in the industry and observers of the industry. I think it's safe to say that the industry has not distinguished itself in foreseeing the risks of that product line, so although long-term care is different in many respects, it continues to be in the back of people's minds. I think that's an issue that the industry is really going to have to continue to address.

MS. MORISATO: That is why there is insurance. We know changes are going to occur. I think companies that have at least a reasonable book of business and are very diligent in monitoring changes will not be taken by surprise, in a sense, that we're going to wake up one morning and go say, oh my gosh. I think that there are changes that could be very significant, but I don't know that they'll occur catastrophically. I think they're ones that certainly would be manageable at the time.

MR. BERG: Companies spend a lot of time thinking about what is going on in society, in terms of advances in medicine. Not a day passes where I'm not struck by the ability of some older person in his or her late 70s and 80s to look great and feel great and for whom the prospect of entering an assisted living or nursing-home facility is the furthest thing imaginable. So it seems—at least for a segment of the population, certainly not all seniors, but for an important segment of the population—that the need for long-term-care, because of advances in longevity and our knowledge of health, is being pushed out. I have been struck by what would seem to be almost common-sense misses on the part of the industry. For example, in 1999, this is a little outside of what we're talking about, but it is related. I think it was Provident that took a very large charge related to advances in the treatment of AIDS. When the first AIDS drugs, the cocktails, were developed in the mid-1990s, and were sort of modified or improved in the late 1990s, some of them made a decision that they wouldn't work or they wouldn't have enduring impact. Ultimately, it cost the company over $100 million, and the stock got crushed when it became apparent that, in fact, people were living with AIDS. This was because, as best as I can tell, somebody in the place was really not reading the research as closely, or there wasn't a broader decision-making process than perhaps there should have been with respect to interpreting the importance of medical research. I just hope the companies stay on top of what's going on with senior health.

MR. ABROE: When will carriers have enough experience in data to know what the future will be?

MR. FORTE: I would say that we will never have enough to satisfy us. Fortunately, there are some developments that are a very positive. Mark Newton and Mark Litow reported yesterday about what the Society LTC Experience Committee has been working on. They have a new intercompany data study with some 17 companies reporting now. This will be available in 2002. They're also working on valuation tables. I think that it should get widespread use and will be welcome, not only by regulators, but by everybody in the industry. So the industry is way ahead of where it was just a few short years ago. It would seem that if more and more companies submit data, the quality of the information that we're getting will improve. So I'm kind of hopeful there.

MS. MORISATO: I think that is true. Having said that, I think that we are learning more about the needs of our claims and how they're progressing. But when you do really look at claims that are 10 and 20 and 30 years out, there are just very significant factors that pertain to that. Medical technology we've talked about significantly. The delivery system itself, I suspect, is going to change very significantly. The presence of insurance dollars will start to change the nature of the facilities—the home-health-care industry and the assisted-living-facilities industry. I think all those changes will have an impact on our claims going forward. There was actually, at one of the sessions yesterday, a discussion that medical technology will clearly lengthen life expectancy. People will be living longer and healthier, but once they become disabled, it's not clear that they won't be disabled longer, because of the life-producing drugs. Is the fact that they delay the onset so many years enough to offset the potentially longer period of claim? The jury is still out on that, and it is something that will require a fair bit of diligence on the part of carriers as they try to monitor that experience going forward.

MR. ABROE: This is our last question, and then we'll open it up to the floor for Q&A. What do you think will separate winners from losers? Please respond from a GAAP or short-term perspective, as well as from a statutory or a long-term perspective.

MS. MORISATO: If you're looking at this over the long haul and short haul, I think this is still a huge focus for this industry. But to be a long-term player and to be one that will sustain itself, you need to build an overall volume that will endure the market—positioning your product or your company in this marketplace in a way that allows you to continue to have a book that will grow, as opposed to just thinking that you're going to be a long-term-care player because the demographics seem right. I think it has to be more complete than that, in terms of what you are trying to accomplish with positioning yourself in that market.

I think the other thing is to continue to strive for clearly profitable growth. Profit is clearly what drives us all, but in the long haul, because of the nature of this risk, I

think scale and the data will be critical in entering this block, going forward. You're going to need to have as much as possible that you can get your hands on and be very diligent about managing and analyzing that data continuously. To be successful in this line really means that the interaction between the pricing and the operations departments has to be constant. It has to be constantly interactive. You need to have those people talking to one another all the time, because if you don't—you can do all the right things, but if one of the operating areas or even one of the elements doesn't work, the product can fall apart. So that means integration and interaction are absolutely critical. At the end, even though this is a growth market, I think it's going to get increasingly more competitive. Companies need to continue to do what they need to do to reduce expenses and to maximize profits.

MR. FORTE: To pick up on the last two points, we really do need to sell with enough margin to allow premiums to stand for what could be a long time. I also think that the point that Eric and Julie made is important. The customers have really strong feelings about this. They are buying a product that they may not use for a number of years, on the basis that the premium will be level. The last thing you want to do is disappoint them or in some way cause them to feel as if they have been misled about what it is that you want. This is really critical. I think that if you're going to be a winner in this market, the last thing you want to do is incur the wrath of the consumer or bring on bad PR. It could cost you millions of dollars to make it up, and you would probably never be able to do it.

The only other thing that we have in this risk, and I think this is important, is to manage the books or GAAP expectations. Shareholders, investors, and their representatives will have expectations. Those expectations will be to see steady, consistent earnings and profitable growth. Eric has called for disaggregated income statements and other tools, like clear and consistent definitions of equity, that will allow people to actually determine what you're earning and when you're earning it. I think winners in this market, at least stock-company insurers, need to be diligent in that.

MS. BURKE: Picking up on something Sue said earlier, I think, with any long-tail-insurance lines, winners and losers are probably determined by two things: underwriting and claims management. With regard to underwriting, there are key factors like family history and current physical conditions, current activities, physician statements, phone interviews, and face-to-face interviews. Claims management—early intervention—delays institutionalization, supports some of the informal caregivers, and identifies chronic conditions early that could lead to further disabilities. I think, from our perspective, those are the two key things. If companies hit those two things right, I think the product will perform well.

I guess from a rating agency perspective, if you're asked what is the potential impact of a long-term-care business on a company's ratings, I guess I'd say a couple things. One is we think it's a rating-neutral for companies where it's done in moderation, with the cost-conservative approach by a management team that

appreciates the risks and manages the risks. We think it can be a rating-negative for a company, if it's (1) growing too quickly, or (2) becoming too large of a part of the overall business. We think over the long term it could be a positive for companies that have successfully introduced this product as a diversifying part of their business. I think that's going to take some seasoning of the actuarial data set, for the industry generally and the emergence of this line as a larger part of the industry for insurers that either hold competitive advantage or have unique experience. I would say, at this point, I can't think of any situation in which we would say it's a positive, just because of the immaturity of the business line and the amount of uncertainty out there.

MR. BERG: Earlier, I had answered the question about what Wall Street wants by saying it wants neither surprises nor disappointments. I meant precisely that. If you look at the great companies, and we define great companies, at least on Wall Street, in a pretty harsh but straightforward way, they're those that make shareholders rich, quite frankly. They are all defined by the consistency of their results. That consistency, in turn, stems from what I would call solidness all around—not brilliance, but solidness—good products that are good values to the consumer. They don't have to be the cheapest, but they're good values. Wall Street looks for investment performance that is respectable—not necessarily top tier, but never missing in a big way. It also wants companies that don't have a reputation for price increases. If the question is directed to me, a Wall Street analyst, the winner is the guy who consistently turns in strong figures, and everything has to be aimed toward that goal. Consistency, over brilliance, is really the key.

MR. ABROE: That ends our prepared questions, and we have a few minutes left for a few questions.

MS. MARY ANDERSON: I'm a retiree from Blue Cross/Blue Shield. My question is for Paul and Sue. I wonder if they would be so kind as to contrast the risk and chance of profit for group versus individual.

MR. FORTE: I think, as Eric said, there is no difference, really, from the viewpoint of investors. Certainly, at my company, there is no difference in what would be expected or tolerated. Our company is looking for steady, consistent earnings. The businesses actually behave, in some ways, pretty similarly. Underwriting is not all together dissimilar, except for the important fact of guaranteed issue on the group side. You do not have enormous commissions and other marketing costs associated with individual distribution. You have significant enrollment costs. With respect to claims payout, of course, you're marketing largely to younger people. Our average age in a group business is in the late 40s and early 50s, whereas in our retail business, it's come down over the years, but it's now down to about age 67 or 68. So, you're looking at serving a group of people who will come into claim much later. There are some differences. With respect to returns, actually, the expectation for group is that since the events will be so far out, and there's more that can intervene between the time you accept an application and the time you pay the claims, there

actually may be heightened uncertainty about what will happen with interest rates and what will happen with morbidity, because you're talking about maybe a 25-year horizon, as opposed to 10 to 15. That factors into the hurdle rates that we're expected to make on the group business, as opposed to individual. In other respects, the management of the assets is done by the same group of people. Underwriting is done, really, by the same group of people. So these product lines are actually quite similar, but there are some important differences.

MS. BURKE: The actual management, I think, is similar, but the trade-off, of course, is that the younger group market is healthier, so the onset of the early claims is obviously less, but the payouts are much further out. Due to the risk of what happens 30 or 40 years out, the risk element is certainly higher. In this elderly market, things are a little bit more immediate on a relative basis, but I would say the profit expectations are also very similar.

MR. FORTE: I omitted to add that, in our company, pricing and product development is done very importantly by the same group.

MR. JAMES GLICKMAN: I have a two-part question. One part is oriented toward the analysts, and one part is oriented toward the insurance companies. Everybody knows that long-term care, because of the long-range deferral of the actual claims, and the ability to get a great deal of growth year after year—30 to 50 to 100 percent annually, by making concessions in either underwriting benefits or premium structures, from the analysts' standpoint, how do they dig in and try to get the real information from the companies that have experienced this growth? Because clearly you can run this business for a decade or more, no matter how poorly you're doing things and still show a very rosy picture. As a side note to that, to what extent do analysts look to other companies in the industry that have had a longer history, to try to get information on some of the newer companies that appear to be doing things either exceptionally well or exceptionally poorly, depending on whom you ask? Then, from the insurance company's standpoint, I'd like to see the flip side of this. How much do companies get influenced to do things, perhaps a little bit more aggressively and perhaps a little bit more inappropriately, in order to meet the short-term expectations that the analysts put on them for growth?

MR. BERG: The short answer is we can't know for sure, because again, as members of the public, we don't have access to the emerging claims data that would point to reserve deficiency. But my view of things—and it does reflect my background as a writer and editor for the *New York Times*—is that a good analyst on Wall Street, just like, I suppose, a good credit analyst is like an investigative reporter. The analyst's job is to approach management's assertion with what I would call professional skepticism, to conduct interviews of management in a way that gets to the key issues. For example, to first identify the key assumptions, and then to explain why those assumptions should be used to reconcile them or attempt to reconcile them with other companies assumptions, and if significant discrepancies emerge, to circle back and say why are you different. As Wall Street analysts, we

can never do this—and this is a mistake that a lot of business people and professional managers make. They expect us to be as knowledgeable about their businesses as they are. That is not possible. Hopefully, most of the people who work in the securities business and major Wall Street firms are reasonably intelligent and curious people. They have the ability to formulate questions. My answer is that it's all in choosing the right questions and watching whether the guy's looking at you or looking at his shoes when he answers the question.

MS. BURKE: I agree with what Eric says. I think there's no doubt that company management always has a spin, and the spin is always positive. I think we try to gain what's called the mosaic theory, where you know various companies that are in this business, and you know what they're reporting and the emerging claims and those sorts of things, so you kind of have to do a test. Does what this company says sound reasonable, relative to what we're hearing from other companies? I think, at the end of the day, the answer is I don't think we really know, and I don't know that the industry knows. So that's one of the reasons why, as a credit-rating agency and as a credit analyst, we are pretty cautious with regard to this product line.

MR. FORTE: To follow up on the second of Jim's questions, which is how do you deal with the pressure that you get from analysts and others who perhaps want to see growth that may not be all that easy to achieve? You've got to make sure that the sales that you're making are made on a profitable basis and not on an unprofitable basis. That sounds so obvious, but it's really important that you do that. For us, this means making sure that the assumptions that we're using in our pricing, are pretty sound, and are not something that has just been adopted or taken on from somebody else. This could be a problem if you have turnover, because people are going to be inclined to take the assumptions, say, in a pricing model that they are receiving and not go over them. Closely aligned to that, though, is to make sure that you really understand what your competitors are offering. You deal with a lot of salespeople who are not all that well trained, and they won't really understand why a competitor is able to offer something at a significant discount. It could be that they have a lower hurdle rate—that their company is not expecting them to make as much money. That's always a possibility. Or they have a different expense structure. It could also be that they don't really know what their competitor is offering. The way to find that out is to go and get their policy forms, study the contract language, and make sure that you have an apples-to-apples comparison. Of course, if you don't, you have to point that out. In the group business, you've got to go right to the benefits manager to make sure he or she understands that it's not apples-to-apples. I found this to be frequently so easy to settle. But it's only when you go to the contract, study the policy form in minute detail, and have people who are comfortable reading these things, that they know in fact that something is being done differently, and that's why the difference is 10 percent. I guess, in short, we're trying to make aggressive sales goals, but they have to be done on a profitable basis. Fortunately, since we have a fairly large book of business, and we're able to re-enroll or get new

enrollments from people who are part of existing groups, we have not had to compete necessarily on a price basis to win new business.