RECORD, Volume 28, No. 2*

San Francisco Spring Meeting
June 24–26, 2002

Session 115PD
Outside Agencies' Views of Health Insurance and Reinsurance Companies (Outside Looking In—How Are We Perceived?)

Track: Health

Moderator: CYNTHIA S. MILLER
Panelists: TIMOTHY W. CLARK†
JOE FRANCE‡
DANA MEHTA§

Summary: Representatives from rating agencies, investment bankers and insurance regulators discuss their views on health insurance companies. Topics discussed include general perceptions of these industries and how those perceptions compare to other insurance, financial and nonfinancial industries. Panelists discuss their views on how recent events, such as the economic climate, the war on terrorism, regulatory actions and initiatives and litigation affect health insurers and reinsurers.

MS. CYNTHIA MILLER: I'm Cindy Miller, and I'm vice president and chief actuary of Anthem, Inc. I'm the moderator for this session this morning. This is session 115, "Outside Agencies' Views of Health Insurance and Reinsurance Companies".

Our panel today is made up entirely of non-actuaries. That doesn't mean that they don't know a lot about our industry, though, as they do.

---

*Copyright © 2003, Society of Actuaries

†Mr. Timothy Clark, not a member of the sponsoring organizations, is a director in the financial services rating group with Standard & Poor's

‡Mr. Joe France, not a member of the sponsoring organizations, is in the equity research department at Credit Suisse First Boston in New York, NY.

§Ms. Dana Mehta, not a member of the sponsoring organizations, is managing senior financial analyst at A.M. Best in Oldwick, NJ.

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

These guys make their living by reviewing, rating, and writing about health insurance companies. We're all affected by the work they do. I think whether you're a consultant or an actuary for a not-for-profit HMO or for a large, publicly traded HMO, we're all dependent upon the ratings that Best's and Standard & Poor's issue. And if you're publicly traded like Anthem is, you're very dependent upon what the analysts write about you.

The panelists are going to share with us this morning what they do as they go through their analysis—the things that they look for, how they review. They're going to share with us some of the outlooks that they have and some of the factors that are affecting our industry today. I think we have a good presentation put together. I'm very honored to have these panelists with us.

I can say that we sometimes have a love-hate relationship with these guys. We love them when they write something good about us or upgrade our rating. We hate it when it goes the other way. But they do provide a valuable service in terms of providing information to consumers and investors about our industry and our companies .

I'll start by giving you a little bit of background on each one of our speakers. Our first speaker is going to be Dana Mehta. Dana is a managing senior financial analyst with the Life/Health division of the A.M. Best Company. In that role, she supervises a team of analysts who evaluate the financial strength and the creditworthiness of most of the large and publicly traded health care carriers, including HMOs and Blue Cross Blue Shield Companies.

Her team also conducts research on industry issues, and I think she's going to share some of that with us this morning. Prior to joining A.M. Best, Dana was a ratings analyst with Fitch, in its insurance group. She also has experience in re-engineering and business analysis in the financial sector and has seven years of group health and life underwriting experience in asset management with CNA Insurance Company. Dana holds an M.A. in management and finance from Northwestern University and is a Chartered Financial Analyst.

Our second speaker is Tim Clark. Tim is a director in the financial services ratings group of Standard & Poor's. He is an analytic unit manager and oversees the efforts of analysts engaged in the full spectrum of insurance risk analysis in addition to overseeing strategic development for S&P's health insurance and managed care rating activities.

Tim has held a variety of positions with S&P, including being a relationship manager in its high-focus analytics unit, and being a team leader overseeing S&P's life insurance rating activities in Canada and the U.S. He also founded and headed up S&P's health insurance division from 1994 to 1997.

Tim has spoken on the topic of insurance risk analysis at national meetings of the Society of Actuaries, the National Association of Insurance Commissioners, Health Insurance Association of America and other insurance industry groups. Tim holds a B.A. in economics from Bucknell University.

Last but not least will be Joe France from Credit Suisse First Boston. He is in the equity research department of Credit Suisse First Boston, and he covers the health insurance and managed care sectors. He also covered this industry at Donaldson, Lufkin & Jenrette prior to that company's merger with Credit Suisse First Boston in October of 2000.

Joe has followed the health care industry for 20 years and currently is responsible for following 15 of the largest publicly traded managed care companies. Joe is definitely regarded as one of the top managed care analysts and is well respected for his coverage of hospital suppliers in the mid-1980s through the mid-1990s.

Joe is a Chartered Financial Analyst. He's a member of the Association for Investment Management and Research and the New York Society of Securities Analysts. Joe holds a B.S. in pharmacy and also an M.B.A. from the University of Kansas.

I'm thrilled to have these people with us today.

MS. DANA MEHTA: Good morning. I'll be speaking about some of the factors and criteria that we use at A.M. Best in determining financial strength, as well as about the creditworthiness or the debt ratings of insurance companies, with a focus mainly on health insurance.

Some of the topics that I will cover here are the rating components that we use, some of the major health rating factors that figure in it, and what drives upgrades and downgrades. We'll take a look at some of the industry segments and what their outlooks are, and then I'd like to say a word or two about what you can do to make our job easier so that we can give you a good, accurate rating. This is a lot of stuff, so I'm going to step through this quickly. If you have further questions, you can certainly see me later.

One thing I do want to emphasize here is that the primary concern of Best's ratings is the security of the policyholder or the debt holder, so our ratings are forward-looking; they're qualitative as well as quantitative. That's where the interaction with the company comes in, when we want to learn the qualitative side of things. And the ratings are designed to identify long-term viability; we don't react on the short-term. That is what gives us credibility with the users of our ratings.

Best's looks at insurance companies based on three major components. The balance sheet strength, of course, is the key to a good, solid rating. The business

profile—all we're emphasizing here is that, in the higher rating categories, the business profile takes on more importance.

We look at information on an historic basis, and we look at all the numbers as well as the qualitative issues on a current basis. This helps us to form a judgment, in which case we can project what the performance of the company is going to be in the future. That is what our rating essentially symbolizes.

Of the three components, the balance sheet is the most important of all. It represents the staying power of the company; it's a cornerstone of the enterprise and shows the ability of the company to weather the storms that may hit it, which we know are plentiful in the health insurance sector.

The operating performance is its earning power, and it goes toward building the financial strength or the balance sheet strength. In that respect, it is important.

The business profile is the marketing power, which is the power over competitors, providers and customers, and which again goes toward the sustainability of the company over the long run. That part becomes increasingly important in the higher-rated companies.

We assign a rating to each one of these and then we average it out to come up with an indicative rating.

In addition to the letter ratings, we also assign rating indicators. This shows the direction in which the rating will likely be used. "Under review" is typically tied to an event. For example, a pending acquisition would be a reason for putting a company under review. It is usually resolved within three to six months.

"Outlooks" reflect longer-term progress within the company and show a gradual improvement or deterioration in a company, leading to an upgrade or a downgrade. Rating action will occur usually in one year but could occur in as many as 36 months.

Now we'll take a look at some of the details that go with these components that I just described. What makes a balance sheet strong? The first thing is the capitalization and leverage. The statutory capital is the single most important criterion that we look at. As far as the health industry goes, a general statement would be that it is undercapitalized as a whole. The Blue Cross plans are probably a little better capitalized than the HMOs. I'll talk a little bit more about capitalization later.

The legal organizational structure of the enterprise determines how cash or money can flow between the different operating entities in the form of dividend payments or capital infusions. Financial leverage, which is the debt level, definitely magnifies

or reduces the risk of the company. Financial flexibility is the ability of the company to borrow money or produce more capital from the outside.

Putting these together, we determine what the capital adequacy is and what the risk exposure of these companies is. The capital cushion generally signifies an excess of capital and is usually negative for health companies. We look at reserve adequacy carefully, as well as contingencies, exposures, litigation, or any pending regulatory actions that may affect the company adversely. We also look at certain off-balance-sheet risks, litigation being one of them.

Looking on the other side of the balance sheet at asset quality, we look at investment quality and especially the liquidity of the investments, the quality of the reinsurance, and the nature and extent of the intangibles.

How does A.M. Best view the business profile of a company? The main thing in the business profile is the franchise, and the franchise determines its competitive positioning and branding. A business mix diversity is something that I'll talk about a little later. I'll also discuss distribution, marketing effectiveness, and provider relationships.

We put these factors together with the prevailing macroeconomic factors in the industry. Looking at the industry dynamics, what strikes us most is the general volatility of the health industry and the impact of inflation in health insurance.

The question is how do these players compete? Do they compete on price, do they compete on service or on product differentiation, et cetera? What are the major obstacles they have to overcome in order to grow? Another factor we may look at is the competitive trends or barriers that may prevail within their local region or, if they're national operators, the trends or barriers within the nation. We also look at the regulatory framework, which is constantly changing.

What is good operating performance? The main thing about operating performance is the profitability. The underwriting and pricing are one thing, and we find that the health industry has done a little better in this respect than the property casualty industry, where the market has been quite soft. That means that the health industry has been able to get price increases fairly readily when it needs it. That's why we have seen premiums grow at double-digit rates over the last few years.

It's really the top line that's driving the profitability at this time. We look at operating profitability and total profitability, because both of them go toward building the financial strength or the balance sheet of the company. We also look at the liquidity that comes from operating cash flow and also the general liquidity of the assets and the investments.

One of the criteria when evaluating creditworthiness is the fixed-charge coverage of liquid cash flows coming in. Putting all of these three together, this is a report card

on the management. From that we determine the quality of the management, the quality of the strategic planning, the level of control that it exercises, the risk appetite that it has as demonstrated in the kind of products the company offers, acquisition activity that it partakes in, and the general track record of the operation.

I named a lot of factors there, so I'm going to talk about of a few of them that we believe are critical to the health insurance industry. Let's look at the first one. How is market segment important? Market dynamics will vary market by market, and we want to know at this point what the differentiating factors for this company are.

Provider contracts are critical because they ultimately drive the relationship with the client and also determine the risk exposure that a company faces, whether it's a full risk, a shared risk, or capitation.

Geographic concentration has a positive and negative side. The positive side is that if there is a geographic concentration, the company can develop a better understanding of its local market, develop better products more suited to the clientele, and serve its clientele a little better than if it was a generalist.

The downside of that, though, is that a company then becomes reliant on the economy of the region and also is subject to the regulatory changes that can come up, which are mainly state-related.

The product portfolio focus on a target market is important, but within that, we look to see if there is enough diversity to serve the needs of that market. Regulatory constraints keep the health industry awake at night most of the time. One of the shining examples of that is the changes in Medicare reimbursements, which have made life difficult for the Medicare + Choice marketers. We also see different regulatory requirements coming up on a state basis, which may show up long after the policies have been priced and may impact the earnings for the rest of the year.

Capital adequacy is the key, of course. We look at the HMO's regulatory requirement, which we believe is extremely low, much too low to define any kind of stability. The A.M. Best’s expectation for having capital at each entity is substantially higher than the minimum requirement.

Surplus notes are not always automatically considered as capital in our calculations. One factor that figures in is who the holder of the surplus note is, whether it's the parent or a third party, and also the amount of financial leverage at the parent holding company.

We look at diversification from the point of view of geographic diversification, which I've already talked about, and also from the point of view of product diversity. Another advantage of product diversity is that a competitor may target a particular

product by aggressive predatory pricing and, therefore, if there are a lot of products out there, there is a little more cushion for dealing with that.

Provider relationships are important, and the provider clout seems to be getting stronger. Hospitals have gone through merger and acquisition activity and have become large and powerful just as the HMOs went through acquisition activity before to become large and powerful.

Another thing is that the providers have put their foot down and said, "If we don't make a profit, we're just not going to do a deal anymore." Ultimately what happens is that if the provider relationships are pleasant, the clients themselves can get better services.

Operating performance is the premiums, the top line that has been driving the profits. We also look at the financials. We treat the small and large companies somewhat differently in looking at the financials. The large companies, we find, have a better ability to anticipate medical cost drivers because they can develop more powerful, better computer systems. The smaller companies are in some ways disadvantaged in this respect. They're not able to build the economies of scale.

Do we look at small companies as being singularly disadvantaged? That's not true at all. What we look for is that, even if it's a small company, does it have considerable market clout in the region in which it operates? That would give it all the strengths that it could need in provider relationships serving their clients.

I'll move on a little quickly here to some of the reasons for some of the downgrades, which is probably of big importance to many insurance companies. The single most important reason for a downgrade is declining capital and most of that has come through continuing operating losses over the past few years.

It can also be because of a declining market presence, because we are forced to exit some product lines because of regulatory reasons and have not come up with other products to replace them. Then again, regulatory changes have been difficult to deal with, especially for smaller companies. There can be parent holding company issues where there is an increasing demand for dividends, and there may be some increased debt at the holding company.

As far as reasons for upgrades, we are seeing that the health insurance industry has made great progress. If there is an upgrade, the biggest reason for it is that the company was acquired by a stronger organization.

We have seen some growth and increase in capital strengths, especially at Blue Cross Blue Shield Companies. Market position is improving, and, again, those are strong at the Blue companies and at some of the larger HMOs. Right now, the capital markets have been looking rather favorably upon the health industry, so the financial flexibility is also improving.

Looking at some of the outlooks on the industry segments, there's little straight indemnity business left; there's virtually none anymore. What we have is the PPO, and that's going to be the growth engine in the health industry going forward. This is also expensive, but it provides choice, which is what people seem to want, and that is what is going to drive continued profitable growth. The Blue Cross Blue Shield Companies' main stronghold is providing PPO services, and most of them have been generating healthy profits from these lines.

Our outlook for that is stable. The prognosis for the HMO industry enrollment is that we expect it to be flat to maybe slightly declining because HMOs are becoming less popular. On the other hand, they are cheaper, so that's a plus for them. We expect profitability to improve because there is more of a focus on the bottom line. We're not going to see too many disasters such as Aetna, where the focus was strictly on the top line and growing size and becoming the largest health insurer around.

But we expect that it will still continue to be a product line that will be offered by the health industry. Our outlook for the larger, better managed companies is stable, and for some of the smaller ones that are still struggling, our outlook is either guarded or somewhat negative.

Speaking of specialty products, they are not always a key to success, although we seem to hear from many of our client companies that that is going to be a major source of their earnings and cash flows.

Looking at disability and long-term care, our outlook is mostly negative. Long-term care is probably not priced correctly and is probably not reserved correctly, mainly because of a lack of good history available. Disability insurance is also quite vulnerable to economic changes.

Dental and vision so far seem to be doing well because the exposure of capital to that area is low; it's a relatively low risk. There has been good growth in that area, and the profitability has been favorable. Our outlook for that is stable to positive.

I'll conclude with how we would like our client companies to interact with us. What we need is good presentation materials. We already have your 10Ks and the statutory statements, so we need to hear more than that from our personal contact. What we want to know is the flavor of the company. We'd like to discuss each major business segment, what the company is doing about it, and whether there are positives or negatives involved with it.

We'd like to see projections and budgets. We'd like to see where the company fits into its economic environment and also within its competitive environment. We do an annual review meeting, where we would like to see the right people who can answer questions for us. We would like you to not forget us once the rating meeting is done, but stay in contact. Be proactive and keep us informed of any events that may be coming up, because we do have an insider relationship with our client

companies. Therefore, we would like to be warned ahead of time of something that may be coming through. What we look for is an open, honest, ongoing dialogue throughout the year.

MS. MILLER: For those of you who don't know Anthem, Anthem is a Blue Cross Blue Shield company, and I swear I didn't pay Dana to say all those nice things about Blue Cross Blue Shield.

MR. TIMOTHY W. CLARK: Good morning. How many of you have any involvement at all with rating agency relationships? A small number. You can tell that those are the people who aren't smiling.

When you go home, if you happen to run into the people who are actively involved with the rating relationships, send them flowers or take them out to lunch; they need all of your help. It's a difficult thing. Dana did a good and comprehensive job in outlining some of the mindsets of A.M. Best, and ours are somewhat similar at Standard & Poor's.

It is a growing challenge because your business is getting more complex. As a result, the analytical tools that we have to use to try to understand you are becoming a little bit more complex. That open dialogue she mentioned is something that's important but makes for a real challenge.

What I'd like to do today is just give a brief overview of the industry and some of our thoughts and perspectives on what's going on. First of all, to remind those of you who are thinking more micro, not macro, we can't seem to get our hands on our health care costs. They keep steadily going up. You can see just what's gone on in the past 21 years. National health expenditures as a percentage of gross domestic product (GDP) are up from 8.8 percent back in 1980 to 16.8 percent in 2000, but already up to 13.1 percent.

This kind of trend makes health care a big deal for us both in terms of the consumer purchasing decision-making and the decision-making process on the part of employee benefit managers, legislators, and everyone else involved. It is, in many ways, one of the more complex insurance markets, because it's one of the few insurance markets where people are as concerned or more concerned about the quality of the service versus the price.

There are some interesting conflicting trends in medical costs. HMO enrollment, which was steadily rising during the mid-1990s, has now flattened out. It has not yet been put in the dictionary that HMO is an expletive, but it's the closest thing to it. If you survey consumers, a pure HMO option is one that's decreasing in popularity.

During the same period that HMO enrollment was first rising and then flattening off, a lowering of medical cost trends started to creep up in the late 1990s. The

strengthening of hospitals, which we'll discuss in just a little bit, has been a driving force as to why medical cost trends are successfully going back up.

Concerning the shift to the providers, you've got to remember that hospitals account for 30 percent of the total medical costs and physicians account for 20 percent. In the mid-1990s, we would talk to organizations like Anthem. I traveled to 49 states and Puerto Rico, talking to different health plans. It wasn't, by the way, a rock concert tour; it's just my job. But in the course of doing that, what we began to realize is that the key to the success of local health plans was the power that they may or may not have in negotiating with providers.

In some smaller markets where there were just one-hospital towns, you'd find health insurance companies that would find their hands tied with respect to their ability to negotiate favorable pricing with hospitals.

However, the greatest strides were taken in the managed care arena in those markets where they were served by multiple hospitals. In that situation, you often could find health plans that could play one hospital off against another to effectively bring those prices down. The hospitals let that trend go on for a couple of years and decided that, if health plans were going to consolidate, so would they.

Consolidation is rampant in the hospital segment. As a result, the pendulum is swinging back in terms of the power of negotiation from the health insurance companies in the mid-1990s to the strengths of the provider in the year 2000.

Overall, we have a stable outlook on the health insurance industry and the managed care industry. Why? Because, thus far, those rate increases that are being put through by providers, accounting for increased medical costs, are being effectively passed through by the health insurance companies to the consumers, and so we're not seeing any kind of pushback.

As a result, it's almost like a return to the old days. People are less concerned about what I'll call invasive managed care protocols and are more interested in choice and effective service. The pendulum has swung back from prior success with capitated products to more open access and broader network blocks.

Basically, if you're not offering choice, you're frankly not in the game anymore. The final point is that the physicians who are being somewhat more passive because of their lack of success in effectively organizing through physician health organizations and other similar models are now increasingly pushing for opportunities to collectively bargain. There are a number of initiatives, legislatively and elsewhere, that could raise the specter of the providers being an important part of the health care medical cost equation.

We do see that there is a potential for some margin pressure down the line. We think that these rising medical costs, while they're going to continue, offer the

potential for some pushback on the part of employee benefit managers. So we think that down the line, within the next year or so, there is some potential for margin pressure.

We see that health insurance companies are hurt somewhat by the reduced investment returns that they're getting off their portfolios, mostly contributed by the weakened economy.

Enrollment is challenging in many ways because of corporate layoffs. That has been a big part of the equation in many of the large states. We're seeing more and more pressure being put on the employees to accept greater responsibility for their health care dollar. There are all sorts of re-shifting of benefits going on including talk about defined contribution. Any opportunity for the employee benefit managers to try and shift some of that cost off of their corporate balance sheets and on to the backs of the consumers is being discussed.

Finally, what we're seeing is the consumers pushing back from the perspective of service and creativity with respect to products, mostly under the umbrella of open-access choice. We're seeing big requirements being placed on the industry to invest in technology, which is going to represent a major initiative on the part of health insurance companies going forward.

As you can see, we have an industry segment that's relatively strong. This is an industry segment that's ranging primarily between the triple B to single A range. There are some select players at the top end of the single A range, but overall, if you look at pretax margins you're seeing for the A-rated players in particular some pretty nice RORs, which actually translate into some nice ROEs. But I'm not going to steal Joe's thunder because he's going to be able to talk better on that.

Let's talk about what's going on in terms of rating changes. The fact of the matter is that the rating changes that you see for 2001, both up and down, reflect not just total groups. For instance, if we're going to change the rating on CIGNA, that's going to be approximately 35 HMOs. So it takes few rating changes in terms of organizations as large as Aetna or CIGNA to result in a large number of changes overall.

What you're seeing overall is that, if you look at just the net difference in 2001, essentially on an overall basis, downgrades exceeded upgrades. We're seeing a reversal of fortune to a slight degree in 2002, again because many of the health insurance companies and managed care plans are performing far better earnings-wise than our original expectations.

We discussed the fact that the insurers are losing the upper hand from a contractual basis. We haven't yet seen the margin pressure associated with that. But down the line, that could be a real issue for the industry.

Employee spending per hour for health coverage, which peaked in 1989, has begun to decrease somewhat. It's the best example of how employers are looking for different benefit structures to pass along those cost responsibilities to the consumer.

I've been analyzing Blue Cross Blue Shield plans and health plans going back to 1986 and 1987. The first time I ever walked into Anthem, I discussed with them my philosophy of corporate strategy, which was the advantage of the Kentucky Fried Chicken syndrome, to which the entire senior management team of Anthem just started rolling their eyes. They never thought that insurance handlers would start using fried chicken as the example of a successful strategy.

A number of us at Standard & Poor's always had a great deal of respect for tightly focused organizations, organizations that didn't overly diversify with respect to the range of business activities they were involved with. As a result, a number of us have a particular affinity for the smaller health plans.

But the advantages of being a smaller health plan in terms of being able to know your customer (because health care delivery and health care financing are local businesses), are now being lost. Technology investments are driving the needs of the industry to build additional scale, and capital is required for that.

It's increasingly difficult for smaller plans to effectively service providers and service their consumer-client relationships with existing technology platforms. It's leading the industry to greater technology investments and setting up the potential for the haves and the have-nots.

Where small plans also increasingly encounter more one-hospital towns where they're negotiating, leverage is somewhat diminished. You can have certain states where things can quickly turn ugly for you. In Washington State in the mid-1990s, they came up with a different scheme for increasing access to individual health insurance and designed the most incredible open-enrollment period, which basically brought the entire health insurance industry to its knees.

We're seeing, for some smaller plans, its social mission. It is going to force them to forego certain premium increases to hold on to enrollment. We see smaller plans as being subject to greater underwriting volatility.

On the legislative landscape, these are known situations. We believe that the Patient's Bill of Rights and others are legislative issues that we're going to be watching closely. There's a real question mark with respect to how a Patient's Bill of Rights could actually be structured.

There is a lot of concern about the state of Medicare, and so there is consideration being given to Medicare givebacks. On the flip side, you think that the drug benefit that's being proposed for Medicare is probably something that's not going to hold

up in Congress.

Let's talk briefly about our rating distribution. The health insurance and managed care industry is a predominantly triple B-rated industry. Let's think of this in terms of where this stands relative to other sectors. We would probably shift the hospital sector's whole bar scale over by possibly as much as one category to the right, which means there would be a greater preponderance of double B-rated hospitals than health insurance companies.

We think that hospitals have been constrained from the point of view of managing both their revenues and costs. They've had some reduced financial flexibility and pressures on financial leverage side, which suggests that a financial profile is not quite there relative to health insurance companies.

If I was going to compare this range distribution to life companies, we have to move all the bars over one category to the left because you see a higher preponderance of double A- and single A-rated life companies in the United States.

So relative to hospitals and life insurance companies, health insurance and managed care companies stand in the middle of those other two industry segments.

Now I will make a desperate attempt to be an equity analyst. To show you where health care stands overall in the spectrum, I thought that we would use the S&P 1500. If you go beyond the index values, you look at a couple things. You look at the relative strength.

Remember that five is best and one is worst. If you were investing in telecom stocks, as we all know, we're not doing so well. If instead you were investing in the consumer segment, you're doing pretty well, relatively speaking.

The health care segment is somewhere in between, but the interesting thing is this relative strength takes in a wide range of factors. If you look at that five-year number, the health care segment has done pretty well for both of those other segments, particularly consumer, over the past five years.

So long-term, it would appear that health care is a segment that's had staying power, and the health insurance and managed care industry segments are an important part of that overall equation. That's all I have to say. I think now I'm going to turn things over to Joe.

MR. JOE FRANCE: Tim, you're probably the only person in America that wants to be an analyst these days. I do follow the equity side of the business as opposed to the fixed-income side, so our emphasis is just a little bit different, although at different points in the cycle, obviously our interests converge quite a bit. On the equity side following health insurance, we do spend a lot more time trying to meet with actuaries than we thought we needed to five or 10 years ago. Obviously, the

business has changed quite a bit, and I'll go through this in my presentation.

I think it's remarkable that three of us, without a whole lot of guidance, ended up leaving room for everybody to say something a little bit different.

Here's a little overview of the industry as we see it. I think the basic take-away is that the growth in the industry overall in the health insurance marketplace is fairly mature. We have growth primarily from market-share gains where we see them in the individual companies. But, overall, the employed population is not growing fast, which accounts for the vast majority of the enrollment among the companies that we follow.

There's only 1 or 2 percent, and when you see companies that are growing much more quickly than that, it's primarily because they're gaining market share. On top of that, of course, as both Dana and Tim alluded to, we are seeing rate increases and, to the extent that they improve profit margins, obviously that contributes to the industry's growth, as well.

Of course, the problem is, on the cost side, that costs are up a lot, too. You don't walk into Sandy Weil's office and ask for a 20 percent rate increase if your costs are only up 15 percent. I think this is one of the challenges that both Tim and Dana alluded to in their remarks.

The population growth is just 1 or 2 percent a year, at least on the commercial side — maybe this year not as much, some years better, some years worse. And even though Cindy is moderating, it is true in fact that the Blue Cross plans are gaining enrollment without any major deterioration, without any change in margins, at a much bigger rate this year than most of the other commercial companies.

Chart 1 is our effort from a layman's point of view to summarize the health care insurance business. Every time I come up with something that I think will make it clear what the industry does, I think I make it more complicated. The idea is just to show we have the most unusual system in the world and that most health care insurance, ignoring Medicare and Medicaid and some other government programs and some employer-sponsored, has huge implications. It seems to aggravate some of the politicians, as witnessed by some proposals put forth yesterday in Washington.

For the time being, it seems likely that the employers will continue to be responsible for a large piece of the health care system in the United States. As a consequence of that, we need to be mindful, obviously, that we all not only work for a company, but they're driving the reimbursement and other things that we need to consider in the health insurance business.

This is just a quick summary. We view this marketplace as a zero-sum gain. Overall population growth isn't tremendous. We are seeing some gains. One of the points

that was suggested earlier that we certainly heartily endorse is that we're seeing a consolidation of the HMO marketplace. When Mount Sinai or some other major institution raises its hospital rates 30 or 40 percent, there's not much an employer can do in the short run.

But one thing an employer can do is shrink the number of carriers it uses. We're seeing a dramatic consolidation of lives among fewer HMOs in meeting with the benefit managers around the country, and we think that's likely to continue. We're also seeing a number of employers moving more and more of the population to the self-insured side. I'll hit on a couple of these points in greater detail as we progress.

The growth of HMOs and managed care converged at a time when managed care was providing a significantly different product than it is today, at least from our point of view. We know that an HMO with 50 doctors in its network is cheaper than a PPO with 500 doctors in its network. But we don't know whether, and there's little evidence to support the view that, with the same benefits, either one of these is cheaper.

Employers are looking at HMOs and deciding that they're not managing care and they're not saving money, so we don't need to pay them a premium to absorb risk. There are some employers who believe that providing an HMO alternative to the self-insured plan maybe increased their overall costs. That's another factor that's driving the consolidation.

I think it's also something that favors health plans in general that have larger market shares because they tend to have better unit costs because of the provider contracting issues that were mentioned earlier, and also the trend seems to be lower.

This gets to the point of how we look at the stocks from the stock market point of view. Chart 2, again from a layman's point of view, is supposed to summarize the basic challenge many of the companies that we follow in the industry faced — not the Blue Cross plans, but a lot of the plans. When the HMO industry started on Wall Street back in the mid-1980s, it started out with plans that had two doctors, one hospital and no choice.

That's an easy product to price. You have tremendous leverage over the beneficiaries, tremendous leverage over your providers, and over the past five or 10 years, we've actually seen an extension, a stretching out, of the underwriting cycle as a consequence of the influence of management on your liability. This means that when you have so much restriction and tighter networks, the effect over the liabilities from the insurer's point of view is much greater. We think that that can begin to reverse itself over the next couple of years.

But this whole curve has shifted to the right. We use flexibility as a proxy — we just say it's all of the things being equal. The bigger your network is, the more the costs

are going to be. A lot of the companies that started out as HMOs are dealing with products today that are much more difficult to price. Without naming any names, there are large companies in the business that as recently as a few years ago had only a handful of actuaries. There are many analysts that probably as recently as five years ago never met an actuary, if you can believe that, not believing that the HMO was in the insurance business, and I think we've got compelling evidence that that is the case today.

So, a whole difference exists today in the nature of the products that are being sold in the marketplace, and that has a huge impact, we believe, on the performance of the companies going forward.

To repeat the obvious, we've seen a huge increase in rates on the HMO and POS side. We've seen big rate increases on PPO, although not quite as much more recently. This process of moving and adding choice and flexibility to the networks has come at great cost. We saw a few months ago that the California Public Employee Retirement System announced that its rate increases were going to average something like 25 percent.

Obviously nobody's claims are growing that fast. But they've gone from a tightly controlled product in a market where rates have been flattened down for a number of years, and we're seeing a huge rate increase. We think these rates are unsustainable.

We start with a view that the employer, who pays a large piece of the total cost in the United States for health plans, cannot afford 10, 15, 20 percent rate increases. If we start with that assumption, then we try to find the companies that we think over the long run have the big market shares locally that will be able to gain a share and provide a slower cost trend.

We may have higher rate increases, and I think Hewitt Associates recently was projecting rate increases of over 20 percent for some segment of the market in 2003, already projecting '03 rate increases. That may be true for the two or three HMOs that are left.

The point I was trying to make earlier is that, since the late 1980s, around '86 or '87, we've had more control over the liability (because of the smaller networks), and more control of the beneficiaries. I think this has contributed to a stretching out of the underwriting cycle. We've had less volatility and certainly greater periods of prosperity.

As we move from a managed to an unmanaged care environment, or to more of a traditional market (we're not going back to the old indemnity side), we think that with this cycle it could be compressed again. We'll see much greater volatility, particularly as employers reduce the number of carriers they work with.
A chart came out in *Health Affairs*, one of my favorite publications, that shows the

annual percentage change in per capita spending. Everybody blames prescription drugs. Two or three years ago, Washington was obsessed with HMOs. Today it's obsessed with the drug companies. Certainly, they continue to contribute to growth in health care spending.

However, the rate increases in hospital activity over the past couple of years have been markedly greater than they were since the early 1990s. We don't think that this is sustainable for a long period of time, but there's no question that hospitals have effectively reduced capacity, not so much by reducing the number of licensed beds, but by converting four-bed rooms to two, and that sort of thing.

As I mentioned earlier, the products that the insurers are selling have bigger networks today, so the leverage that the insurers enjoyed, particularly from an HMO's point of view, has been diminished by this process.

To understand our view of the relationship between HMO pricing and hospital rate increases, in general, we've seen in the past a three- or four-year lag between the peak in the rate increases that the insurers get and those of the hospitals. That would suggest if our theory is correct that, in 2002, if this is the peak in terms of the rate increases for the insurer's side, we could see two or three more years of rate increases on the hospital side. That does not speak well for margins.

Concerning what drives stock valuation in the sector, I think the point that we would want to make is that we think there will be a consolidation in the industry. There will be fewer HMOs. We've found that, even at First Boston, we have about 8,000 lives in a self-insured PPO, and we have about 7,000 lives in two HMOs or POS plans. That's down from seven over the past five years.

We looked at combining all 6,000 of the lives in these HMOs into one plan. Not only would we get a discount from the one plan that would get all the lives, but we also found that, because there's 98 percent overlap in the networks, only 50 employees would have to change physicians. This is another factor that I think drives the consolidation and another reason why we favor companies with bigger market shares.

Rather than walk through some of the regulatory issues that have already been mentioned, maybe we can just open for questions. I will show you this graph to give you a perspective on stock price performance in the marketplace since the mid-1990s. Back in April 1995, Len Abramson, who ran U.S. Healthcare at that time, since acquired by Aetna, had a medical loss ratio of 70 percent, and he said he was going to use it as a strategic weapon. That contributed to the competition and the difficult environment for a lot of the companies over the next couple of years.

Even though we had spectacular performance in 2000, when the tech stocks peaked, more recently we've had rotation on pharmaceuticals and other health care

businesses. Over a long period of time, I think it's clear that the managed care performance hasn't been great. We've been going forward, but there will be substantially greater divergence in performance. Thanks.

MS. MILLER: We'd like to open it up to any questions you might have.

MR. ROWEN BELL: This question is for the rating agency panelists. Tim, your chart was particularly interesting showing the histogram of where the managed care companies sit in terms of your rating tiers.

There are a small but substantial number of health companies that have varying capitalization, strong and consistent profits, strong market share, and brand recognition. Yet these companies are not only not in the top tiers of your rating system, but they're not A double plus by Best, they're not triple A by S&P, nor in most cases are they even A plus by Best or double A by S&P. What I would like to know is if you can imagine circumstances under which a monoline health insurer could be in the top tier of your respective rating systems.

What sort of characteristics would a company have to have in order to accomplish that? It's a bias against the health industry on your part that it's just not possible for a health company to be as sound as a triple A-rated life company.

MR. CLARK: You were doing fine until you mentioned triple A-rated life companies. There's a decreasing percentage of life companies in America that are rated triple A. With respect to life companies or any company, I said the worst rating in many ways to have these days is a triple A rating because it affords you reduced flexibility to do all the things that you want to do.

But let's go back to health plans. Take a company or health plan that has good capitalization, good earnings, and good liquidity. How could we possibly keep an organization like that out of the double A rating category? I'll use three words: control of destiny. We don't have a public rating on them now, but back in the early 1990s, there was an organization called Blue Cross Blue Shield of Alabama.

You're talking about an organization that has, by some measures, a 57 percent share or maybe 70 percent share, depending on how you want to measure that market share. The Alabama gang, I'll use that phrase, controlled their destiny. Organizations like UnitedHealthcare, highly regarded, have tried to come into Alabama, and the former chairman of the Alabama plan, Gene Thrasher, basically said, "When we see the big boys come, we walk right up to the border, shake their hands and say. 'Welcome to our state. We'll be back here in three years to shake your hand when you walk out.'"

There are organizations like the Alabama plan, like Trigon and others, that truly do control their destiny, and there are real opportunities for those organizations to be rated in the double A range. But frankly, as our average rating has come down for

all sectors, our average rating for health plans has come down somewhat.

If I were a health plan today, I'd be pleased and proud to have a single A range rating from S&P because that's something that you can leverage in the marketplace and affords you the flexibility to do the things you want to. The further you go up that rating scale, the more difficult it is for a plan because, all of a sudden, it has to start adhering to very strict rating agency targets, which limit its flexibility. Dana, do you have anything to add?

MS. MEHTA: I can add a little bit more to it, and that is A.M. Best's perspective is that, in the industry, the top rating that we are giving right now is about an A rating. That is on the A.M. Best scale, which would be approximately equal to an A plus rating on the S&P scale.

Having said that, I would say that we are seeing gradual improvements in the industry. The focus on earnings has improved, and therefore we may be willing to evaluate in a little while to see if we can give a rating that's higher than A. But that's assuming that the focus of the industry remains on the bottom line. Because it appears that once the industry is making enough money, it forgets about the bottom line and goes for the cutthroat top line, and we need to be convinced that that's not going to happen.

The main criterion, as Tim said, is that there is a lack of control on what goes on. If you compare it to the life industry, where there are some triple A-rated companies, it has stable businesses and huge blocks of regular ordinary life insurance, which just pumps out money day after day after day. That does not happen with the health industry.

The cost inflation is one thing everyone is going to have to deal with, not just the providers or writers of the insurance. Everyone is suffering from it. Unless some of these major problems and handicaps that the environment has are not brought under control, we cannot see a triple A-rated health company.

MS. MILLER: I have a couple questions if nobody else has one right now. I'm curious as to how, for each of you, the recent scandals such as Enron and WorldCom and all the questions now that are out there about corporate finances in general have affected how you do your jobs?

MR. FRANCE: From an analyst's perspective, this is one industry, from an equity point of view, where we have some of the poorest disclosures or the fewest disclosures of any other companies. Anthem, as it turns out, actually discloses more about its reserves than anybody in the industry, by a considerable degree.

But I'm frequently asked, as Enron and all these other things have developed over time, what the potential accounting issues in our industry are. First of all, we've had

consolidation, and we've had acquisitions, but not one a week. And not every one is bigger than the last one.

It is true that the things that we don't know are the ones that come back to hurt us the most, and there are the fewest disclosures on reserves. When you see companies fail, in the past, it was always a surprise because there was no indication. We don't see the triangles that we see in the life business, for example, on the health side, I guess, because the tail is so much shorter.

We don't see any of the obvious things. WorldCom was capitalizing expenses, and Tyco is making dozens and dozens of acquisitions and not exposing them. It makes us more wary. In general, it has increased the tone of concern in the industry. But if you look at the stocks, it has been a haven for most investors in the managed care area because it's one area where we don't see a lot of problems.

MR. CLARK: I think from our perspective, first of all, a rating agency analyst by his or her nature is a naturally cynical animal so that when you introduce an Enron situation, they say, "Cynicism is good." How we find ourselves reacting is that we feel more comfortable with what I call cleaner companies, companies for whom their notes to financial statements can not qualify as the plot line for a miniseries. We find that organizations that are less rapid on the acquisition front are ones that we tend to feel more comfortable with.

If there is a dramatic mindset, it is the developing bias that it's more difficult for you now to prove to us that your next great acquisition is going to be truly successful over the long term. I think that we push management teams hard on that. Fortunately, we haven't had a lot of turnover in many of the managed care and health insurance organizations on the top-most ranks of senior management, so their credibility has been proven to us. But when you get someone new coming in, you're going to, in some ways, start from scratch.

MS. MEHTA: Many of our client companies have mildly suggested to us that rating agencies are famous for locking the barn door after the horse is gone. That, to a degree, may be true in some respects. One of the things that we have been doing is looking at investment portfolios a little more closely to see what they have invested in.

With Enron, when the debacle broke loose, what we did was go through all the Schedule Ds with a fine-toothed comb. I'm happy to report that we found almost nothing drastic in the health sector. We found plenty of terrible stuff in the life and property casualty side, but little in the health side.

Having said that, I don't want to imply that we think that the health industry is a saint. It has its own ways of doing funny things, and we'd like to think that once we identify what an industry tends to do, we tend to examine those things a little more

carefully. So far, we have not had any reason to suspect the health industry of having done offshore deals or having offshore debt.

I'm speaking strictly from a domestic point of view. I think that there is reason to suspect that in the international ones and in the global ones. I think our focus, therefore, is more on how they represent capital at this time, rather than what they invest in.

Having said that, we know that some of the Blue Crosses and the not-for-profit ones have been rather heavily invested in equities, so we are taking a harder, closer look at the Schedule Ds and asking more questions in that respect.

MR. CLARK: Just one final thing. There was a lot of screwing around in our shop on the issue of liquidity post-Enron, but basically we've been running liquidity models on industry segments going back over 10 years, and, basically, as we stress-tested those models further, we found that there was no additional risk than what we originally assumed.

MS. ESTHER M. BLOUNT: I have a question. With respect to a lot of the large life annuity carriers, there's a feeling that if you have health on your block, it's pulling down your rating. As a result, we've seen a lot of them get out of medical — sell it off — and that reduces the diversity that you're seeing that would take care of the underwriting cycle.

Do you think that the fact that the rating agencies rate down the health side is good for the consumer and the public?

MR. CLARK: Well, I'll take a shot at that. Standard & Poor's has been involved with about 95 percent of those committees that resulted in our revising some ratings on life companies in part because of their health exposure. We think that highly rated companies are those that execute well in their chosen segments.

What we never did was say, "Because you have health insurance, we're going to lower your rating." What we did say is that, because you have health insurance, and you're not doing as well in that health insurance sector as some others, your rating is increasingly going to come under pressure.

That's resulted in a number of players getting out. What's interesting is Joe's slide, where he showed the Blue Cross Blue Shield underwriting cycle. Since we began doing that, the underwriting cycle has become somewhat more appealing than in the early years. We think that, increasingly, health insurance is being concentrated in the hands of those that do it well.

Back in the early 1990s, there were over 75 Blue Cross Blue Shield plans. They're now back to numbers down below 40, and I think America is better off for that. I also think that the further consolidation on the part of health care financing toward

those organizations that specialize in health insurance makes all the sense in the world

That's why I think, from a consumer perspective, that there's higher quality service being given to the consumer today. There's more choice, and the trends are better now than they were 10 years ago when there was greater diversity with respect to the number of health insurance companies.

MS. MEHTA: Looking at insurance companies over the past several years, the conclusion appears to be that they are required to have a focus in order to be successful. They just simply are not able to be all things to all people. And the ones who seem to do a decent job of selling life and annuities don't seem to be able to do a decent job of selling health insurance.

They were not downgraded because they sold the health insurance; they were downgraded because they sold health insurance badly. We're talking about a lot of small companies who just simply couldn't afford to go out and build networks.

Large companies, like Travelers and Metropolitan, at that time MetLife, were not able to do it, so they created this Metra Health monster and sold it to United, which turned it into a marvelously profitable enterprise.

Another example I will quote is somebody like Principal Life. It has done a wonderful job of marketing its pension products to small and medium-sized employers. That again is a cutthroat business, where the competition comes from mutual fund companies and certain banks, and Principal Life has been able to meet that competition. But it did not do such a healthy job of managing its health insurance. As a result, that wound up being scaled back quite a bit. The company took most of the business and sold it to Coventry.

It appears that no matter how large, powerful, and well managed a company may be, it cannot do everything perfectly, and one or the other of it has to go. If you look at it on the other side, take the example of CIGNA . It has done a good job of developing the health side as well as all the other employee benefits. It has done a good job of marketing the individual life insurance also, but it was not able to generate the high level of profits it was getting from others, and so it divested that segment.

It's not always that the health insurance went. Sometimes the life insurance went, too.

MS. MILLER: Just one final question for all of you. You've got a captive audience of actuaries here. Any words of wisdom or any pleas for what we should do or shouldn't do as we rate and reserve business?

MR.CLARK: I will say that I have conducted countless numbers of management

meetings over the years, and I come in these meetings thinking I know a heck of a lot. The most formidable experience for me is when I'm sitting across the table from an actuary who is an effective communicator, because in that situation I'm dealing with someone who's got all the homework done — that's always an assumption in your profession. But also, that person can marshal the facts in such a way to identify the large trends, the implications, and the why behind the numbers.

Any of those individuals is incredible from the perspective of dealing with management meetings. I'll just say one other thing. This is a brief anecdote about how the actuarial profession may not be totally understanding on the health insurance side. Years ago, the chief financial officer (CFO) of a major managed care company came to us and said, "We figured out our business, and we're going to withdraw some capital from our business because we don't need that capital. We can put it toward amusement parks or something."

I said, "Okay that's great. Why don't you come on in and talk to us." I had the chairman and the CFO there. First of all, they said, "You know, rating agencies know nothing about health insurance companies, and that hurts our brilliant new business. I thought, "Okay, that's good. Now I have a friendly way to start off the conversation."

I said fine and what about capital? He said, "How do you determine how much capital you need? We maintain whatever levels of capital that we are instructed to maintain by the rating agencies." I thought, "This is cool. We don't know anything, but then you look to us to determine the capital level."

I asked, "If rating agencies weren't around, how much capital would you keep?" He responded, "We don't need that much capital because we're a service business." I said, "Every week, I go to my dry cleaner. That's a service business. Are you a service business like dry cleaning?" He said yes and wanted to know how many actuaries dry cleaners have — he didn't seem to know.

I said that I maintain that one health insurer employs more actuaries than the entire dry cleaning industry. I suggest there's a fair amount of risk that you guys are assuming, and I would listen to your actuaries to better understand the true implications of the risks you guys are assuming.

So, you guys hold all the cards.

MS. MEHTA: Maybe the health insurers feel that the rating agencies don't know much about the health insurance industry, but after talking to a variety of different health insurers, small to large, low-rated to high-rated, we tend to come to the conclusion that maybe the health insurance industry doesn't know much about the health insurance industry.

The reason for that is there is really no way of knowing what's happening to the health insurance industry because of the general lack of control. It's a runaway engine. There is inflation out there that nobody knows what's going to happen with it. There is a regulatory environment out there that really nobody knows what you're going to do with or what may come up out of the blue.

It seems to be almost impossible to time a pricing cycle with the experience that has been observed, because the experience going forward will probably not be the same as what it was in the past. What we'd like to see in the industry is an awareness of the fact that it doesn't know things, and then you can deal with that.

I think what really makes the industry so interesting is there is no time to take a nap on the job because there's always something happening. We are always dealing with three or four fires at a time. Generally, what we tend to favor is at least an acknowledgment on the part of management that everything is not in the realm of the known. There is a lot out there in the realm of the unknown, and while actuarial science may produce a lot of precise numbers and probabilities, they're still probabilities.

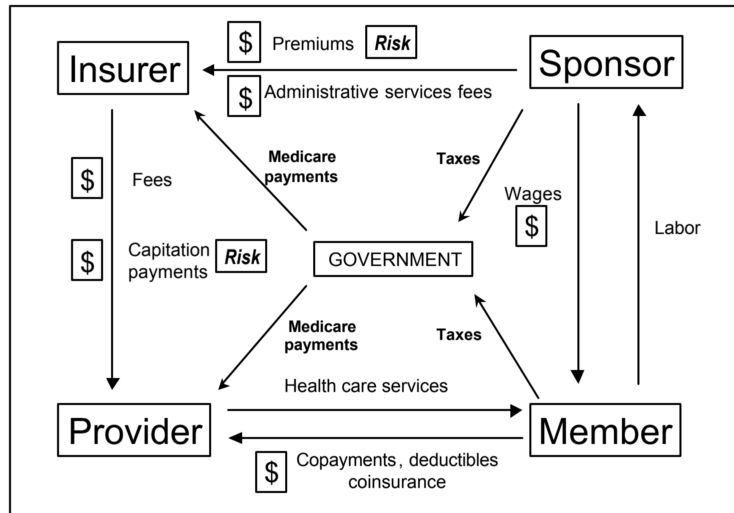
MR. FRANCE: I would just underscore what Tim alluded to. We think that the disclosure needs to be tremendously greater in the industry. Most of the major companies have a large number of actuaries working for them and most of them have really good computer systems, and when I go see them, the people who run them seem to be smart when you talk to them.

But the records of the companies are uneven, to say the least, in the industry. I think to the extent that that reflects variation in management to the disclosures, this could help modify the unevenness a little bit.

MS. MILLER: I'd like to thank our panelists again since they all took time out of their schedules to come be with us. Thank you.

Chart 1

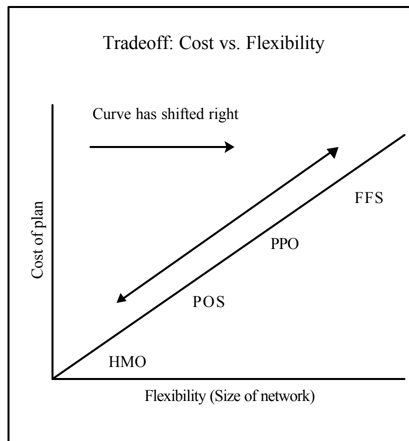
Health insurance: the players...



June 26, 2002 — *Credit Suisse First Boston Health Care Group* — Figure 5

Chart 2

This is an *insurance* business!



- Many of these companies started as HMOs, with little choice and small networks
- Many companies have added new products, but have not underwritten, or priced them correctly
- More flexible products, with larger networks are harder to price
- Impact of financial incentives is more difficult to estimate than the old method: "Just saying no!"

June 26, 2002 — *Credit Suisse First Boston Health Care Group* — Figure 8