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Reawakened Focus

of IDI Carriers in the Physician Market

by Robert W. Beal

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Physicians have represented a major market for many individual disability income (IDI) carriers over the last 30 years. The emphasis on doctor sales brought the IDI market to its knees during the 1990s. Since then, claim experience has slowly improved and industry profitability has recovered. But lackluster sales have encouraged many IDI carriers to return to aggressively targeting doctors, raising the fear that the difficult lessons of the 1990s may well be forgotten.

The Lessons of the Past

The excesses of the IDI market during the 1980s and the first half of the 1990s have been well documented.[1] There was a period of about 15 years, beginning around 1980 when IDI carriers by and large threw caution (and sound risk management principles) to the wind. Products were continuously liberalized, premium rates dropped and underwriting became lax as companies competed for more and more sales.

At this time, physicians were viewed as the ideal market. They were considered the premier motivated professionals with a strong appreciation of the value of IDI insurance. Carriers offered physicians their richest policies (e.g., noncan, pure own occupation, cost-of-living benefits, and lifetime benefit periods) and the highest amounts of coverage. Monthly benefits of $25,000+ were not uncommon among medical professionals. For many of the key IDI competitors, doctors represented at least 30 percent of their in-force premium.

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Until the early 1990s, the morbidity experience associated with physicians was favorable, but this trend reversed sharply when physicians' income and motivation dropped as the medical industry suddenly shifted more to managed care, the cost of malpractice insurance continued to climb and universal health care became a distinct possibility. Many physicians who had been working with potentially disabling conditions realized that their IDI policies allowed them to maintain their lifestyles and avoid the economic realities of their profession and subsequently filed disability claims.

Chart 1 compares IDI industry new claim incidence rates (as percentages of 85 CIDA rates) for medical occupations during the 1990s to those of non-medical executives, physicians and white-collar occupations combined. These results are from a study conducted by the Individual Disability Experience Committee (IDEC) of the Society of Actuaries.[2] The chart shows claim incidence for medical occupations increasing in the early 1990s and remaining high for most of the decade thereafter. In comparison, new claim incidence for non-medical occupations, which are lower than medical incidence, were relatively stable for the first half of the 1990s and then reducing steadily thereafter.

The downturn in the medical market and the excessive practices of IDI carriers led to dramatic financial losses for IDI carriers during the first half of the 1990s, peaking in 1995. As a result of the unprofitability of their IDI businesses, over thirty-five carriers exited the IDI market, many of whom sold their in-force businesses to other IDI carriers.

Since approximately 90 percent of the business was noncancellable, the remaining IDI carriers were unable to increase premiums or modify contracts on in-force business. However during the second half of the 1990s, they were able to focus their efforts on rehabilitating their IDI products on new sales and avoiding markets that were contributing a disproportionate share of the financial losses. Carriers instituted significant tightening of their products and underwriting practices and increased premium rates on new sales. Most IDI

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[1] One source is the paper written by this author titled, "Individual Disability Income Insurance in the United States," 2006. The paper is available at *www.soa.org*.

[2] "Report of the Individual Disability Experience Committee Analysis of Industry Experience from 1900 to 1999," available at *www.soa.org*.

carriers restricted the types of coverage offered to doctors and other medical occupations and lowered their maximum issue limits to these occupations to $10,000 or less. As a result of these actions and a fortunate stabilization of the claim experience on the older business, the overall profitability of the industry has been able to slowly turnaround.

The history of severe IDI losses during the 1990s followed by a road to recovery is well illustrated in the annual studies of the statutory profits of the noncancellable IDI business[3] performed by Mark Seliber and Duane Kidwell for many years. Chart 1 shows the pre-tax statutory margins for years 1988 to 2006 from their most recent study for 16 IDI carriers which represent a large majority of the IDI market.

Re-emerging Focus in the Physician Market

While it is clear from this chart that industry profits have been strong since 2000, new sales have been stagnant. A study of the IDI market conducted by Milliman in 2007[4] showed that new premium grew at an annual rate of less than 1 percent over the 2002-06 period. As a result, competitive pressures have returned as many carriers are chasing the same traditional IDI markets, including physicians. Milliman's 2007 IDI Market Study showed that 22 percent of all new premiums in this five-year period has been from sales to physicians, second only to executives. Premium share for doctors for at least four of the more active IDI carriers exceeded 30 percent. At least half the IDI carriers will now issue $15,000 of monthly benefits to doctors and participate at $20,000 or higher.

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Chart 1: *IDI Industry Claim Incidence Rates During 1990-99*
Occ Class 1 (Executives, Professionals and White Collar Occs)

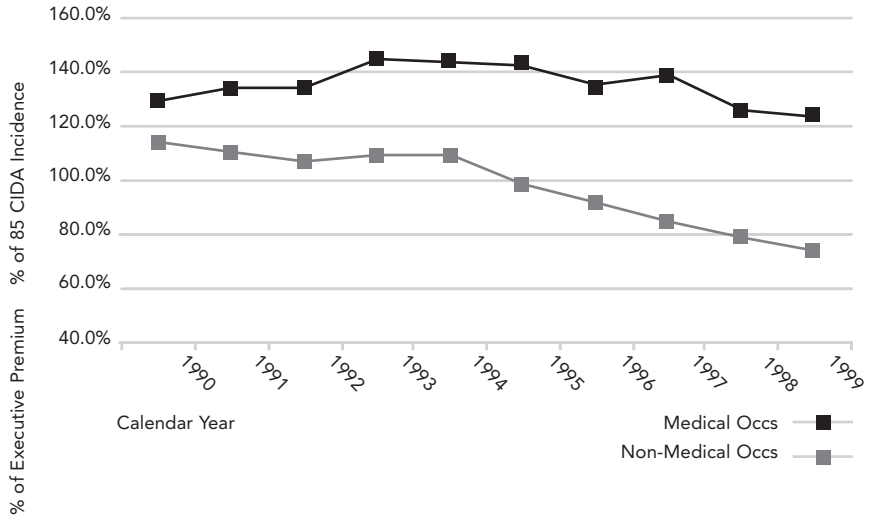
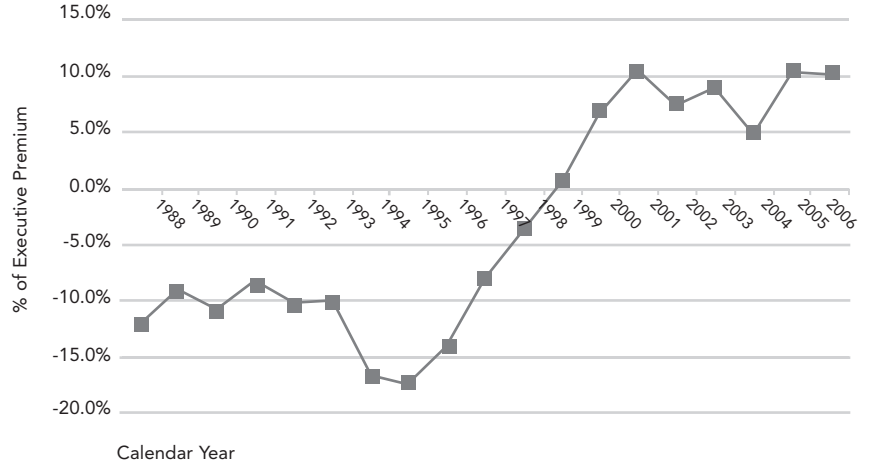


Chart 2: *Statutory Pre-tax Profit Margins After Dividends*
16 Companies



[3] The most recent study was published in Milliman's Disability Newsletter, August 2007.

[4] Milliman's 2007 IDI Market Survey may be obtained by contacting the author (*bob.beal@milliman.com*).

priorities might differ and what you consider to be important might not be mentioned. Another reason is that the more someone hears a given message, the more likely they are to believe it. Last, but not least, there will be some members or staffers who will accept input from one source, but not another. Do what you can and let others do what they can.

Even if you are one of the few actuaries who can participate from a company standpoint, also support the efforts of your trade associations and the American Academy of Actuaries. If nothing else, the more people who consider a proposal, the better the resulting analysis.

Point #5 - There is such a wealth of material to consider and analyze that you will need a process to work through it and to be prepared to react quickly to changes and new proposals.

The following is a high-level overview of the process I attempted to follow 16 years ago. (Not the one I started with, but the one I ended up using because it worked.)

1. Review the high-level proposals. Begin to understand the broad structures that each proposal follows. Put the proposals into categories based on the overall structure of the resulting health care system.

2. Attempt to forecast the impact of the changes made by the proposal to the current health care system.

   A) Evaluate the ability of your company to participate in the changed system.

   B) Evaluate the ability of your competition, both current and possibly new, to have significant new market advantages.

   C) Evaluate the ability of the proposed market to maintain long-term stability.

   D) Evaluate whether or not the keys to market success under the proposed system would be significantly different from your current keys to market success.

   E) Evaluate, as best as possible, if the current health care cost increases continue to escalate above growth in GDP, where the pressure point on revenues will be. In other words, if costs continue to rise rapidly, will the impact be first felt by employers, who will then attempt to pass the costs along to employees; or, will the impact be felt on tax revenues, which the government might attempt to control by reducing provider reimbursements, or something else?

   F) Evaluate the impact of the proposal on key stakeholders: U.S. citizens, employers, health care providers, health care research and development, and government at all levels

3. Determine which general approaches are overall positive, neutral or negative and why (with specifics).

4. List the key details within each major general proposal.

   A) Repeat step #2 above for each key detail.

   B) Roll up the results for each proposal and put a value on each proposal

5. List critical issues in detail with the specific reasons they are critical. Few people and even fewer companies like change, but even though some change is deadly, other change might be neutral or positive. As much as possible, try to avoid negative evaluations simply because the system would change.

   A) List the general approaches that simply won't allow your company to participate in the proposed system.

   B) List the general approaches which might or might not allow your company to participate in the proposed system, depending on certain key details

   C) List the general approaches, which are likely to produce a future system in which your company can continue to thrive.

   D) Prioritize your key issues. This includes high-level proposals that don't work, or key details within high-level approaches that determine whether or not the proposal would work.

   E) Look again in depth at your list. Are the issues for your company also issues for the general public, or employers, or even the government? If your company is adding value to the system, then there probably is a strong correlation between

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issues that your company will face and issues that participants in the system will face.

F) Develop "story boards" or scripts that attempt to clearly describe the issues and how they will impact the people of this country. Unless you are talking to your local member of the House, most of your potential audience will not care much about the survival of your company. They will care about how it will impact voters.

G) Through whatever route you have, take your message to everyone who is willing to listen.

6. Review all new proposals and changes to existing proposals, and repeat the whole process.
7. As time allows, exhale.

Point #6 - You can expect that both the American Academy of Actuaries and the Society of Actuaries will be active in this effort.

The Academy, as would be expected, will focus on direct contact with the Hill and analysis, while the SOA will focus on needed research and analysis. Look for calls to participate and, if possible, find ways to contribute. This issue impacts all of us and is vital to the future of our country. To the extent we can add our knowledge to the results, we can create a better future for all of us. ■

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Carriers tend to justify this renewed interest in the physician market by pointing to their stable claim experience since the late 1990s and higher premium rates charged for physicians and other medical occupations. However, this rationalization may be ignoring certain underlying economic realities facing U.S. health costs. For example,

- The most recent Physician Environment Index[5] published by the Massachusetts Medical Society, incorporating nine factors that impact the delivery of patient care in Massachusetts and the United States, deteriorated at an annual rate of 1.21 percent from 1992 to 1999 and 3.03 percent from 1999 to 2006.
- The 2007 Report of the Social Security Administration described the critical financial issues facing both the Social Security and Medicare programs and raised an alarm about the inaction of our government to address these issues. The report states, "Medicare's financial difficulties come sooner-and are much more severe-than those confronting Social Security."
- After the 2008 presidential election, there may be a renewed focus on fixing the issues associated with medical costs and the availability of medical insurance through some form of universal health care. Such discussions as well as the solutions, if they should emerge, could ignite a deterioration of physician claim experience similar to that seen in the mid-1990s.

Aggressive marketing of noncancellable IDI products with larger amounts of available coverage today appears to be short-sighted with respect to the current economic pressures facing physicians today and in the near future. Allowing over a quarter of IDI sales to be issued to physicians places the hard fought positive profitability of the industry at risk and ignores the lessons of the IDI industry's not-too-distant past.

Is There a Solution?

It is inevitable that physicians will continue to seek IDI coverage and companies will want to provide it. Physicians will always be a significant segment of the IDI industry. The higher premium rates that companies now charge physicians, which resulted from companies creating separate occupation classes for medical professionals, suggest that the today's products may be appropriately priced to reflect physician experience over the last ten years. However, abandoning many of the risk-related controls implemented in the late 1990s and allowing physicians to represent an increasing proportion of new sales could make IDI carriers' future profitability vulnerable.

The solution is not an easy one. It involves exercising discipline around the maintenance of sound risk controls and fostering an awareness that the economic turmoil facing the medical world during the early 1990s could very well occur again. Last but not least, the solution involves recognizing that a sound strategy for increasing new IDI sales should not rely solely on the physician market. ■

[5] *The Massachusetts Medical Society Physician Practice Environment Index Report*, MMS Index Report March 2007. *www.masmed.org*.