



# HEALTH SECTION NEWS

"For Professional Recognition of the Health Actuary"

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## Chairperson's Corner

by Thomas R. Corcoran

Our newsletter editor, Leigh Wachenheim, has asked me to discuss some of the activities the Section undertook in 1997 and our plans for 1998. As incoming Chair of the Health Section, I look forward to serving you and thank you and Leigh for this opportunity.

The primary role of the Health Section is to help health actuaries keep abreast of a rapidly changing environment through SOA-sponsored meetings, the *Health Section News*, the SOA web site, and distribution of information directly to its members. The Section also addresses the educational and research needs of health actuaries.

One of the most visible roles of the Health Section is to sponsor and organize sessions for Society meetings. Last year was very successful in this regard. The Health Section sponsored programs for more than 40 sessions at the health Spring meeting in Palm Desert and 17 sessions at the Annual Meeting in Washington, D.C. This was a major undertaking, involving dozens of volunteers who developed program content and recruiting hundreds of

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## Special Report: The LTD Market—A 1997 Update

by Michael D. Lachance

**Editor's Note:** *This article summarizes the results of the LTD Profitability and Market Survey performed by Disability Reinsurance Management Services, Inc. (Disability RMS), a Maine-based disability reinsurer, and continues the annual survey begun by John C. Antliff. Since group long-term-disability (LTD) insurance is combined with other group health insurance products on the NAIC annual statement, financial information on group LTD is not readily available. This survey helps to bridge the gap by providing a means for monitoring industry results.*



Profits for 1996 began what we expect will be an increasing trend for the LTD industry over the next several years. Risk management actions taken by LTD insurers over the past few years increased aggregate net gain after taxes for the industry from 0.1% in 1995 to 1.2% in 1996. Additionally, the number of insurers surveyed that posted losses for calendar year 1996 decreased by 20%, dropping from ten in 1995 to eight in 1996, and the average loss for these companies dropped 29%, from \$7.5 million to \$5.3 million.

Table 1 on page 7 shows the aggregate Statutory LTD results of the 23 insurers that contributed their net gains after taxes to this twelfth annual survey. These results include 11 of the top 15 U.S. LTD insurers and represents almost 50% of estimated U.S. premiums earned during 1996. In total, 31 companies contributed information to this survey, including all of the major U.S. LTD writers.

The figures in Table 1 are direct as to reinsurance and do not include premium equivalents for Minimum Premium Plans (MPP) or Administrative Services Only (ASO) contracts. These numbers represent U.S. business only. Net gains include investment income,

while experience refunds and income taxes are deducted.

### Sales

Table 2 on page 7 shows annual sales growth since 1982 for companies that contributed gains and for all companies contributing to the survey. Sales are measured by annualized premiums, including extensions of old cases, but not normal growth or rate increases.

Aggregate LTD sales growth dropped significantly for both company groupings. There was a greater reduction in sales growth for the 23 companies contributing gains (9.4% in 1996 versus 24.1% in 1995); however, this growth rate is still almost 40% greater than the 6.8% average growth in sales reported by all contributing companies. Additionally, 1995 was a very strong sales year for the group of companies contributing gains. This reduction in sales growth is not surprising as most companies have shifted their attention toward returning their existing blocks of business back to acceptable profitability levels. It will be interesting to see whether this becomes a permanent long-term shift or a temporary adjustment in management expectations.

### Earned Premiums

As was seen in last year's study, for those companies contributing gains, the average annual compounded growth in earned premiums has grown at an accelerating rate throughout the period of the study: 4.2% from 1982 to 1987; 8.7% from 1986 to 1991; and 12.1% from 1991 to 1996. Year-by-year results are summarized in Table 3 on page 8. This growth rate acceleration is not present in the group containing all contributing companies. Earned premium growth for the companies contributing gains was 18.1% in 1996, the highest level ever reported by this group of companies. For all contributing companies,

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**Chairperson's Corner***continued from page 1*

volunteer speakers. On behalf of the Health Section, I would like to thank everyone who participated, especially Dave Bond and Jim O'Connor, who coordinated the spring and annual meetings, respectively.

Planning for the 1998 meetings is already in full stride. Jim O'Connor is leading the Health Section's efforts to present 44 sessions in Hawaii, and John Heins and Bob Beal are currently developing session descriptions for the Annual Meeting in New York City.

The second critical element to help members keep up with changing times is the *Health Section News*. In 1998, we are planning a full slate of four editions. We strongly encourage all of you to submit articles to our newsletter editor so we can meet this goal. We are off to a good start—this edition of *Health Section News* provides excellent examples of addressing a changing environment.

These include Lee Launer's article, which addresses the rising relevance of alternative care, and Mike Lachance's article updating us on the financial fortunes of the LTD market. Peter Hardee's article and Keith Sloan's comments provide assistance in keeping cancer tables timely. A spring edition is already in the planning stage. It will include a discussion of the results of the recent membership survey, among other

issues.

The third main area the Health Section addresses is the support of research and education activities on behalf of health actuaries. The Health Section Council works jointly with the Health Benefit Systems Practice Advancement Committee of the SOA on several fronts, including:

- Addressing the education and research needs of practicing health actuaries
- Expanding recognition of health actuarial skills and expertise by potential customers and the general public
- Meeting the needs of specialized health practice areas (for example, long-term care, disability, and so on)
- Recognizing the role of health actuaries in public policy issues
- Strengthening ties with nonactuarial centers of influence, such as academia and regulators
- Sponsoring research efforts to define and measure the effectiveness of managed care processes.

The last category I would like to cover involves providing services to the Health Section membership. In 1997, we provided each Section member with "Statistics for Employee Benefit Actuaries" and made the "Employer Benefit Re-

search Institute Databook" available to members at the bargain price of \$10. We have also started to make health morbidity tables and other research studies available on the SOA web site. Finally, we conducted surveys of both members and employers of health actuaries to determine where to direct our efforts in 1998.

I would like to wrap up this column with a recognition of the efforts of the 1997 Health Section Council and a request for help for the current council. First, I would like to recognize the outgoing chair, Tony Hammond, for his hard work, and recognize the Section Council, including outgoing members Barbara Niehaus and John Woolsey for the accomplishments of 1997. I would also like to recognize the SOA office staff who actually do most of the work.

Second, I would like your participation in setting goals for the Health Section in 1998. The role of the Council is to represent the interests and needs of the Section membership. This is particularly difficult for the Health Section because of the great diversity of its membership, which represents a broad array of products (medical, managed care, group life, individual disability, and so on), areas of expertise (product, financial, sales, operations, and so on) and constituencies (insurance companies, HMOs, consulting firms, reinsurers, and so on).

We need you to express your views on where the Health Section needs to go and how it should get there. Please contact any of the members of the Health Section Council with your ideas or especially to volunteer your assistance. The Health Section members need to be the catalyst for action; the Section Council will provide the focus and methodology.

The Health Section Council, the *Health Section News* editor, the Society staff, and I are looking forward to a happy and productive 1998, with your help.

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# Adjusting the 1985 NAIC Cancer Claim Cost Tables for Inflation

by Peter G. Hendee

The 1985 NAIC Cancer Claim Cost Tables (cancer tables) are a collection of morbidity tables. They contain the annual claim costs per person by attained age for each of several benefits typically found in 1970s- era cancer insurance policies. The cancer tables refer to these benefits collectively as the "standard plan."

The standard plan provides hospital indemnity benefits (payment of a fixed amount for each day of hospitalization due to cancer) and reimbursement of certain cancer treatment expenses. There are limitations on the reimbursement payable. For example, radiation therapy and chemotherapy expenses have a lifetime limit of \$1,000.

Cancer policies marketed since the 1970s typically have higher benefit limits than the standard plan. The newer policies with higher benefit limits typically experience higher claims. The cancer tables include formulas for calculating what multiple of the standard plan claim costs should be used for policies with higher limits.

The cancer table formulas for adjusting claim costs for changes in benefit limits are based on benefit costs during the experience period underlying the table. The cancer table formulas appear to anticipate that provider charges for services and supplies may vary with the benefit limits, but they are not intended to reflect changes over time in provider charge levels or in medical practice patterns.

If provider charge levels increase and policy benefit limits are increased by the same percentage, then claim costs experience should also be expected to increase by that percentage, provided medical practice patterns do not change. For example, if surgeons' fees have increased to five times their level during the cancer tables' experience period, and the frequency of various operations does not change, then a surgical schedule which is five times the standard plan's schedule should have five times the standard plan's surgery claim costs. The formula in the cancer tables produces a multiple of only four, a 20% understatement. This is because the formula was not designed to reflect increases in provider charge levels over time.

One method for reflecting inflation in the cancer table formulas is to increase certain constants in the formulas in proportion to changes in provider charge levels. Exhibit 1 on page 4 illustrates this type of adjustment. The formula constants which have been indexed are underlined.

The original cancer table formulas for which inflation adjustments are appropriate are shown in Exhibit 2 on page 5. These formulas are for the following benefits: surgical, anesthesia, radiotherapy and chemotherapy, and blood and plasma. The adjusted formulas, with provision for increases in provider charge levels, follow the original formulas. When benefit limits are increased by the same percentage as provider charge levels have increased, the adjusted formulas indicate that claim costs should also be increased by this same percentage.

*continued on page 4, column 1*

by W. Keith Sloan

Many actuaries who now use the 1985 NAIC Cancer Claim Cost Tables have been kept in the dark about their background. The tables required a great deal of time to produce and the accompanying paper has taken even longer. Peter Hendee is right in that the plan maximum adjustment mechanism is no longer, probably, valid. A short reference to their history seems to me to be in order.

## The "Standard Plan"

The primary reason for choosing "standard plan" was that a table based on those benefits had already been produced and published (TSA XXX, pages 49-55). Because the table was not actually based on cancer insurance experience, it was not accepted for its stated purpose, which was to provide a badly needed valuation basis. In fact, the "standard plan" was obsolete at the time work on the 1985 NAIC Cancer Claim Cost Tables began, though there was a great deal of insurance in force on it and similar plans.

The plan maximum adjustment Hendee discusses in his article was needed for two purposes. First, we needed a means of converting the data we had to a common basis to produce coherent results as we worked on the tables. Second, users of the NAIC tables needed a way of developing appropriate factors for the particular plan being valued. (Two members of the committee sent in listings of variations of benefits plans then in use. One showed 17 plans in that company and the other 14 plans in several companies.)

## An Alternative Adjustment Method

Quite early in the study, the committee considered a more accurate method for adjusting for plan maximums. This method used a technique shown in Bartelson's *Health Insurance* text published by the Society of Actuaries in 1968 (pages 143-44). This method, as it was applied to the 1979 cancer experience of a major contributing company, is demonstrated in the example in Table 1 on page 6.

Unfortunately, few actuaries had access to spreadsheet programs at that time, and the linear approximations finally developed are much simpler to use. However, with spreadsheets, the original methods suggested for surgical and anesthesia schedules may be better. As a matter of fact, I have had occasion to use them and found them satisfactory.

The purpose of Table 1 was to show that the ratio of average maximums between plans can be quite different from the ratio of maximum maximums. It is easy to see that the ratio of each Plan B average maximum to each Plan A average maximum (1.9 and 2.7, respectively) is not equal to the ratio of each Plan B maximum maximum to each Plan A maximum maximum (2.4 and 4.3, respectively). It is also noticeable that the relative frequencies are not the same for the two benefits. (These relative frequencies should be either validated or updated to reflect changing practice patterns.)

*continued on page 6, column 1*

**Hendee***continued from page 3*

No inflation adjustment should be made to the formulas for drugs and medicine, nursing, physician, and transportation benefits. The formula adjustments for these benefits already produce an increase in claim costs in direct proportion to any increase in the benefit limit.

The procedure in Exhibit 2 is designed to adjust for increases in provider charge levels. It is not intended to adjust for

changes in medical practice patterns. For example, the adjusted claim costs do not reflect any changes in the frequency of surgery or other treatments.

*Peter G. Hendee, FSA, is a consulting actuary with Odell & Associates, Inc. in Winston-Salem, North Carolina.*

**EXHIBIT 1****Original and Adjusted Formulas for the Surgical Benefit Claim Costs Multiple****Original**

The original formula for the surgical benefit claim costs multiple is:

$$\frac{200 + 0.3 \times (\text{limit} - 500)}{200}$$

For example, the table multiples for \$1,000 and \$2,000 benefit limits, based on the original formula, are:

$$\frac{200 + 0.3 \times (1,000 - 500)}{200} = 1.75$$

$$\frac{200 + 0.3 \times (2,000 - 500)}{200} = 3.25$$

**Adjusted**

The adjusted formula for the surgical benefit claim costs multiple, reflecting a doubling of provider charge levels, is:

$$\frac{400 + 0.3 \times (\text{limit} - 1000)}{200}$$

The table multiples for \$1,000 and \$2,000 benefit limits, based on the adjusted formula, are:

$$\frac{400 + 0.3 \times (1000 - 1000)}{200} = 2.00$$

$$\frac{400 + 0.3 \times (2000 - 1000)}{200} = 3.50$$

*continued on page 5*

**Hendee**

continued from page 4

**EXHIBIT 2**  
**Formulas for Which Inflation Adjustment Is Appropriate**

Inflation adjustment is appropriate for the following 1985 NAIC Cancer Claim Cost Table formulas. The constants which should be indexed in proportion to changes in provider charge levels are underlined.

**Surgical Benefit**

$$\frac{\underline{200} + 0.3 \times (\text{limit} - \underline{500})}{200}$$

**Anesthesia Benefit**

$$\frac{\underline{70} + 0.3 \times (\text{limit} - \underline{100})}{70}$$

**Radiotherapy and Chemotherapy Benefit**

$$\frac{\underline{333} + 0.2 \times (\text{limit} - \underline{1000})}{333}$$

**Blood and Plasma Benefit**

$$\frac{\underline{170} + 0.2 \times \text{limit}}{230}$$

These formulas, adjusted for an  $x\%$  increase in provider charge levels, are shown below.

**Surgical Benefit**

$$\frac{[\underline{200} \times (1+x\%)] + 0.3 \times (\text{limit} - [\underline{500} \times (1+x\%)])}{200}$$

**Anesthesia Benefit**

$$\frac{[\underline{70} \times (1+x\%)] + 0.3 \times (\text{limit} - [\underline{100} \times (1+x\%)])}{70}$$

**Radiotherapy and Chemotherapy Benefit**

$$\frac{[\underline{333} \times (1+x\%)] + 0.2 \times (\text{limit} - [\underline{1000} \times (1+x\%)])}{333}$$

**Blood and Plasma Benefit**

$$\frac{[\underline{170} \times (1+x\%)] + 0.2 \times \text{limit}}{230}$$

The change in provider charge levels,  $x\%$ , should be measured from January 1, 1979, the center of the experience period underlying the cancer tables, to the date as of which claim costs are being established. And provider charge levels for various services and supplies may not all change at the same rate, so "x" may vary by type of benefit.

**Sloan***continued from page 3***Additional Considerations**

Mr. Hendee also mentions that if provider charges increase and policy benefit limits are increased by the same *percentage* (emphasis added), then claims cost experience should also be expected to increase by that percentage, provided practice patterns do not change. A comparison of the various RVS values will show that increases are seldom across the board. In a personal example, I have noticed that a \$50 benefit for skin cancer removal in the past three years more than paid the fee. I am certain that cannot be said for the more extensive procedures.

I am concerned much more about adjustments for the radiation-chemotherapy benefit. Sadly, the only solution I have to this is that a new study of that benefit (at least) be undertaken. Chemotherapy was far from a common treatment during the exposure period, and the real "standard plan" did not contemplate its use at all. There was also a fad about the time the table was published of recognizing that chemotherapy was not used much by making that benefit unlimited. Many of the companies

that did so have had to impose substantial rate increases, some offering reduced schedules instead. This problem could easily produce cumulative antiselection.

Also, note that for waiting periods of at least 30 days, the committee found no measurable selection or antiselection. I once made a study of waiting periods in cancer insurance (now lost) that showed that the optimum waiting period is 30 days.

If a group of sufficiently brave souls can be found to volunteer to update the table, they might also look into the question of reduced hospital stays. That could include the "drive-by mastectomies," which are being condemned in the media.

Mr. Hendee is to be commended for bringing this problem to the attention of the Health Section.

*Keith Sloan is a retired actuary living in Tennessee. He served as co-chairman of the committee that developed the 1985 NAIC Cancer Claim Cost Tables.*

**TABLE 1**  
Comparison of Plan Maximums

Body Site	Surgical Schedule			Anesthesia Schedule		
	Frequency	Maximum		Frequency	Maximum	
		Plan A	Plan B		Plan A	Plan B
Buccal Cavity and Pharynx	1.93%	200	200	2.51%	70	100
Digestive System	14.90	500	1,000	19.18	70	250
Respiratory System	9.27	400	800	11.46	70	200
Bones and Joints	0.54	300	500	0.78	70	125
Skin	31.31	50	75	7.56	70	50
Breast	9.48	300	600	14.39	70	150
Female Genital	8.77	400	600	14.59	70	150
Male Genital	5.74	400	700	8.47	70	175
Urinary System	8.84	400	1,000	11.22	70	250
Brain	0.75	500	1,200	1.25	70	300
Endocrine System	0.66	300	400	1.12	70	100
Lymphomas	2.87	400	500	2.88	70	125
Leukemia	1.13	400	400	0.26	70	100
Other Hematatic	0.58	400	400	0.30	70	100
<b>Total/Average</b>	96.77	288	546	93.49	67	181
Ratio of Plan B Average Maximum to Plan A Average Maximum	1.9			2.7		
Ratio of Plan B Maximum Maximum to Plan A Maximum Maximum	2.4			4.3		

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*continued from page 1*

**TABLE 1**  
**LTD Growth and Profits (\$ Millions)**

Year	Sales	Earned Premium	Net Gain after Taxes		Number of Insurers w/Loss	Losses	Average Loss
1982	68.6	757.1	77.5	10.2%	3	-3.9	-1.3
1983	71.4	757.6	105.6	13.9	4	-1.8	-0.5
1984	88.9	789.0	121.9	15.4	1	-1.4	-1.4
1985	118.9	843.1	120.9	14.3	2	-2.9	-1.5
1986	133.5	886.2	123.5	13.9	4	-8.3	-2.1
1987	142.5	928.8	87.1	9.4	7	-17.1	-2.4
1988	209.2	1,013.3	89.4	8.8	6	-15.7	-2.6
1989	224.4	1,155.4	111.4	9.6	8	-14.2	-1.8
1990	219.3	1,253.3	136.7	10.9	4	-8.0	-2.0
1991	220.3	1,347.2	117.9	8.8	7	-15.6	-2.2
1992	271.1	1,427.0	119.0	8.3	4	-19.6	-4.9
1993	283.3	1,579.6	63.7	4.0	7	-12.5	-1.8
1994	306.8	1,714.0	-20.9	-1.2	13	-63.5	-4.9
1995	380.8	2,019.0	1.5	0.1	10	-74.5	-7.5
1996	416.5	2,385.0	28.3	1.2	8	-42.3	-5.3

**TABLE 2**  
**Sales Growth**

Year	Companies Contributing Gains			All Contributing Companies		
	Sales	Sales Growth	Five-Year Average Sales Growth	Sales	Sales Growth	Five-Year Average Sales Growth
1982	\$ 68.6	-	-	\$150.5	-	-
1983	71.4	4.1%	-	159.7	6.1%	-
1984	88.9	24.5	-	198.6	24.4	-
1985	118.9	33.7	-	233.0	17.3	-
1986	133.5	12.3	-	247.7	6.3	-
1987	142.5	6.7	15.7%	234.6	-5.3	9.3%
1988	209.2	46.8	24.0	332.6	41.8	15.8
1989	224.4	7.3	20.3	387.2	16.4	14.3
1990	219.3	-2.3	13.0	401.0	3.6	11.5
1991	220.3	0.5	10.5	413.2	3.0	10.8
1992	271.1	23.1	13.7	498.4	20.6	16.3
1993	283.3	4.5	6.3	536.6	7.7	10.0
1994	306.8	8.3	6.5	605.1	12.8	9.3
1995	380.8	24.1	11.7	661.8	9.4	10.5
1996	416.5	9.4	13.6	707.0	6.8	11.3
1982-1987	-	15.7	-	-	9.3	-
1986-1991	-	10.5	-	-	10.8	-
1991-1996	-	13.6	-	-	11.3	-
1982-1996	-	13.7	-	-	11.7	-

the growth declined from 11.5% to 7.1%. The five-year rolling compound average growth rate for all contributing companies has been remarkably stable since 1989.

**Net Gains**

Generally speaking, the factors contributing to the improvement in profitability are well-known to those involved in managing LTD for their employers:

- Greater emphasis on profitability versus growth

- Increase in new case prices

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TABLE 3  
Premium Growth

Year	Companies Contributing Gains			All Contributing Companies		
	Earned Premium	Earned Premium Growth	Five-Year Avg. Premium Growth	Earned Sales	Earned Premium Growth	Five-Year Avg. Premium Growth
1982	\$ 757.1	—	—	\$1,457.9	—	—
1983	757.6	0.1%	—	1,522.1	4.4%	—
1984	789.0	4.1	—	1,617.6	6.3	—
1985	843.1	6.9	—	1,773.4	9.6	—
1986	886.2	5.1	—	1,872.6	5.6	—
1987	928.8	4.8	4.2%	1,962.9	4.8	6.1%
1988	1,013.3	9.1	6.0	2,155.5	9.8	7.2
1989	1,155.4	14.0	7.9	2,413.6	12.0	8.3
1990	1,253.3	8.5	8.3	2,709.0	12.2	8.8
1991	1,347.2	7.5	8.7	2,917.8	7.7	9.3
1992	1,427.0	5.9	9.0	3,062.0	4.9	9.3
1993	1,579.6	10.7	9.3	3,353.1	9.5	9.2
1994	1,714.0	8.5	8.2	3,639.6	8.5	8.6
1995	2,019.0	17.8	10.0	4,056.7	11.5	8.4
1996	2,385.0	18.1	12.1	4,345.5	7.1	8.3
1982–1987	—	4.2	—	—	6.1	—
1986–1991	—	8.7	—	—	9.3	—
1991–1996	—	12.1	—	—	8.3	—
1982–1996	—	8.5	—	—	8.1	—

- Aggressive renewal actions for unprofitable segments
- Aggressive claims management
- Development of products that support claims management and/or limit benefits.

These factors not only should improve results in the short term, but also, most importantly, if the industry can maintain the discipline it has exhibited over recent years, these factors should create a more solid foundation for better long-term results as well.

Assuming that the two company groupings have similar compositions and thus underlying underwriting experience, it is possible that the gains shown by the 23 companies contributing gains slightly understates the actual experience for the industry in total. While small in magnitude, many companies experience some surplus strain on new LTD business and thus lower statutory earnings. Since this company grouping has had higher growth, their

reported earnings may be lower as a result.

**Pricing and Rating [1]**

In last year's survey, a number of companies indicated that they were in the process of either introducing or refining pricing differentials based on geographic location of employee groups. In order to gain a better understanding of the current practices in this regard, we asked survey participants a series of questions about geographic pricing. The results are shown below.

**Does your company have rating adjustments by geographical location such as state or zip code?**

Response	Percentage of Responding Companies
Yes	87%
No	13%

**If yes, what is the range of adjustments from the highest cost to the lowest cost factor?** (for example, smallest: 0.90; highest: 1.10; == > Range = 20%)

Response	Percentage of Companies Responding "Yes"
< 20%	15%
20%–30%	27%
30%–40%	38%
40%–50%	8%
> 50%	12%

Interestingly, while many companies indicated activity in this area in last year's survey, 80% of the companies' responding "yes" to these questions indicated that the range of values had remained the same in the last 12 months. Thus, it appears that companies were "tinkering" with rates by either

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increasing or decreasing rates for specific geographical areas rather than increasing the overall range of loads or discounts. However, the percentage of companies using a fairly wide range of factors (58% of companies responding currently use a spread of 30% or more) shows that companies are already taking geographic location heavily into account in their current rating practices.

Another area of activity, mentioned in last year's survey, was pricing flexibility. We thought it would be of interest to delve a little deeper into this issue so we asked the following questions.

**Does your company allow rating flexibility by your sales personnel on a case-by-case basis?**

Response	Percentage
Yes	69%
No	31%

**If yes, what is the range of discounting available?**

Response	Percentage of Companies Responding "Yes"
< 10%	21%
10%–20%	47%
> 20%	32%

When analyzing rate competitiveness, most people would tend to focus on a comparison of manual rates. However, with a large percentage of LTD insurers utilizing rating flexibility "pools" in their sales offices, an analysis of manual rates may not adequately address sales force complaints about uncompetitive rates. Furthermore, given the high degree of utilization of this concept, a LTD insurer is probably at a significant disadvantage if it does not have some form of pricing flexibility.

**Sales & Marketing Analysis**

Responses to last year's survey indicated a consensus that the LTD market has been very competitive over the last few years. We attempted to get a better "pulse" on this issue by asking several questions about sales goals and closing ratios. The results of our inquiries are discussed below:

**Did your company meet its 1996 sales goal?**

Response	Percentage
Yes	63%
No	37%

**If yes, what was the percentage over goal? If no, what was the percentage under goal?**

Companies Responding	Average Percentage Over/Under Goal
Met goal	18%
Did not meet goal	-23%

**What was your LTD closing ratio for 1996? What is your LTD sales closing ratio target?**

	Closing Ratio
Actual	8.0%
Target	9.5%

While 97% of the respondents indicated that competition in 1996 was either "the same" or "more intense" than in 1995, almost 2/3 of the responding companies achieved their sales goals. Given the number of comments concerning the competitiveness of the LTD market in the last two surveys, one could have expected an even greater proportion of companies to miss their sales goals in 1996. On average, those companies that met their sales goals exceeded them by 18%. The magnitude of this variance was somewhat higher than we expected because of the concerns that companies have about market competition. For those companies that failed to meet their sales goals, they missed the mark by an average of 23%.

Regardless of whether companies achieved their sales goals in 1996, there was widespread dissatisfaction with actual closing ratios. More than 60% of respondents indicated that they were not happy with their closing ratios. This is not surprising given the disparity between target and actual closing ratio results from our survey. Historically, we have seen companies achieve a 10% closing ratio, which is fairly consistent with the average target closing ratio of 9.5% from the survey respondents. However, actual closing

ratios were 20% less than this figure, possibly indicating a high degree of competitive pressure and/or ineffectiveness by some carriers distributing LTD products.

**New and Continuing Developments**

Survey participants were asked to comment on their own company's progress in group long-term disability and other developments in the LTD marketplace. All the companies made at least a few comments including those that did not provide their net gains. Highlights of these comments are captured below.

**A. Product Development**

New product development was, by far, the area receiving the most interest in our survey. Most companies indicated that they either recently introduced new product enhancements or were currently developing LTD product enhancements to be introduced in 1997. Unlike the proliferation of increasingly more-liberal product features in the 1980s and early 1990s, during this cycle, companies are focused on developing products that will enhance the ability to manage claims and/or limit benefits. Some of the specific areas receiving the most attention include:

- Subjective (self-reported) illness limitations
- Special conditions limitations (mental and nervous, drug and alcohol, soft-tissue injuries, chronic fatigue)
- Integrated STD/LTD/managed-disability product
- Own-Occ/ADL definition of disability
- Increased incentives to return to work
- Mandatory rehabilitation
- Must receive Social Security benefits to continue receiving benefits after the own-occupation period

While the emphasis was on the development of lower-risk products,

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survey respondents also shared concerns regarding this trend:

- ADA challenge to mental and nervous limitations (Parker v. Metropolitan)
- Potential impact of an adverse result in the ADA challenge to mental and nervous spreading to special conditions limitations
- Carriers stripping-down products to get low rate on spreadsheet; broker ignorance of product increases reliance on rate. Consumers may not understand benefit differences and, thus, what they are buying

**B. Sales and Marketing**

- Increasing distribution capacity
  - New sales offices
  - Alternative distribution (TPAs, MGUs, and so on)
  - Mergers with health care companies (for example, HMOs)
- Lower emphasis on new sales == > greater emphasis on placing renewals and persistency of in-force cases
- Large-case companies venturing into small-group market and vice versa
- Greater demand for integrated STD/LTD and managed-disability products

**C. Underwriting**

- Leaner plan designs
- Strict renewals
- More segmentation to better understand block profitability

**D. Pricing and Financial**

- Expanding field rating flexibility
- More attention on sold-to-manual ratio
- Aggressive renewal rating

**E. Claims Management**

- Increased emphasis on managed disability, early intervention, and rehabilitation
- Strengthening claims organization and practices
- Proactive approach to settlements
- Hiring of specialized expertise: doctors, nurses, psychiatrists, Workers Compensation adjusters, and so on

**Future Outlook**

Figure 1 shows the yields on 10-year Treasury Notes for the period January 1994 through April 1997. During this period, yields on 10-year Treasuries were at their lowest point during January of 1996 but increased by 125 basis points by mid-year. There was a general downward trend during the second half of the year, which has since been reversed due to inflation fears by the Federal Reserve generated by a very strong stock market. Rates are still relatively low as compared to historical periods (particularly pre-1994) and, hopefully, LTD insurers have adjusted prices to account for these lower rate levels. In any case, higher interest rates would generate higher investment gains on reserve balances, further improving financial results for LTD insurers. A rate hike by the Federal Reserve Board (FRB) caused a short-term correction in the stock market in 1997. While the FRB has not taken additional actions since then, inflationary fears could cause rates to increase again.

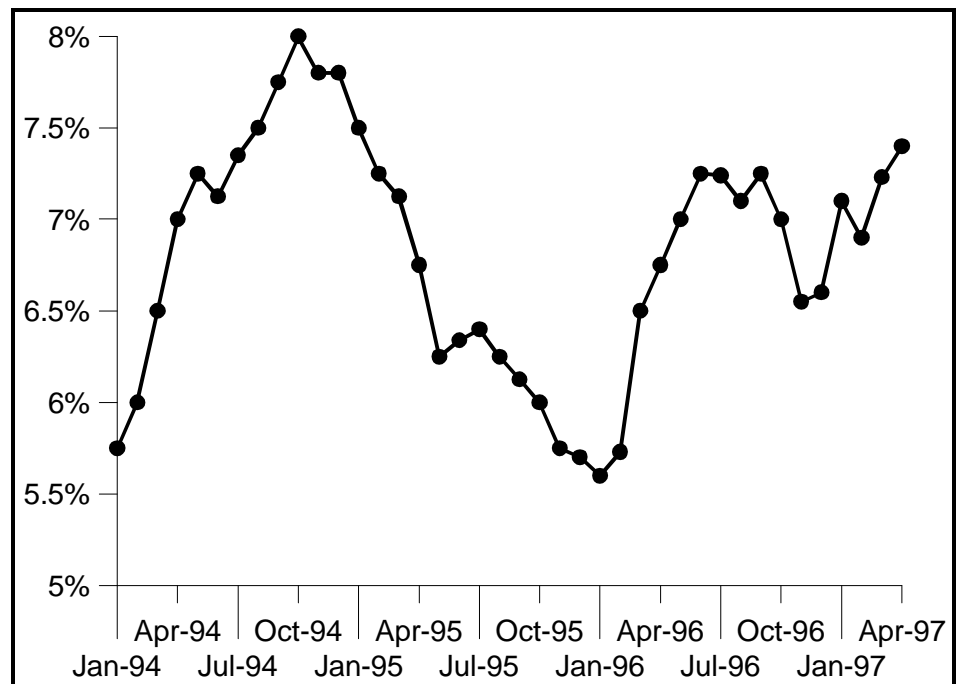
The U.S. unemployment rate has steadily declined from its peak in 1992, which has probably contributed to the more favorable incidence rates experienced by LTD carriers over the last few years. However, LTD carriers should monitor differences in the unemployment rate by geographical region or industry to avoid potential restructurings that could have an adverse impact LTD experience (Figure 2 on page 11).

The Consumer Price Index has been kept low and stable at 3% (or less) since 1992. While this is good for the price of goods and services purchased by U.S. consumers, salaries and wages have also been kept in check. This restricts the natural growth in LTD premiums and, more importantly, potentially reduces the incentive to return to work that might otherwise be created if a claimant's purchasing power is quickly being eroded by inflation.

In last year's survey we anticipated that results could improve by 2%-4% of earned premium. Profits for 1996 were better than for 1995 by about 1.1% of earned premium, somewhat shy of our expectations. However, 1996 results were weighted down by a couple of carriers that experienced

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**FIGURE 1**  
 Yield on 10-Year Treasuries



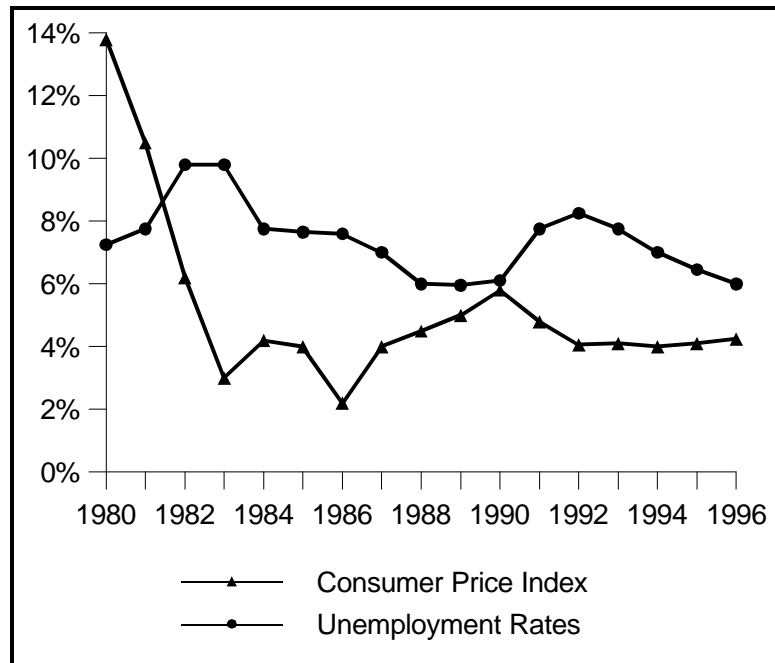
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unusual losses in traditionally profitable segments during 1996. The reason for these losses was not related to that for the losses that have plagued the industry over the last few years, and these companies have categorized them as temporary fluctuations. In fact, they have already seen improvement in these segments during the latter part of 1996 and early 1997. Without these "fluctuations" the improvement in profitability for the industry would have been within the 2%-4% of earned premium range.

In contrast, at the recent Health Meeting of the SOA, representatives of the individual noncancellable disability industry seemed rather pleased with the fact that the representative companies in the noncancellable survey had "only" lost \$486 million on a pre-tax basis in 1996 versus \$581 million in 1985! While there is more work to be done, the LTD industry has responded to the challenge, and profits appear to be heading in the right direction. With continued discipline we expect that profits for the LTD industry should continue to rise by another 1%-3% of premium during 1997.

Many of our contributors expressed concern with their ability to contribute to the survey because of a lack of resources. However, in the end, they all recognized the value of the information being gathered and, somehow, found the necessary resources to submit their contributions to these results. Disability

**FIGURE 2**  
**U.S. Economic Statistics**



RMS would especially like to thank everyone who found the time and resources to contribute to the survey this year. Without their assistance and support, this survey would not be possible. If you are interested in contributing your company's data or have suggestions for improving the survey, please call us at (207) 775-2054 or send a fax with your comments to (207) 775-2478. We would appreciate hearing from you.

*Michael D. Lachance, FSA, is President of Disability Reinsurance Management Services in Portland, Maine and a member of the SOA Reinsurance Section Council.*

**END NOTES**

1. This survey did not involve the gathering of information regarding, and is not intended to convey, actual prices or price differentials of any insurance products or actual pricing by any LTD insurance entities.

**A Call for Papers**

Actuaries are invited to submit papers for possible publication in the *Journal of Actuarial Practice*, an international referred journal. Papers may be on any subject related to actuarial science or insurance; they do not have to contain original ideas. Preference will be given to those papers intended to educate actuaries on the methodologies, techniques, or ideas used (or can be used) in current actuarial practice. The journal also accepts technical papers, commentaries, and book reviews. However, all articles must have some relevance to actuarial practice.

Please send an abstract of the paper by Friday, May 1, 1998 and five (5) copies of the completed paper by Friday, June 19, 1998 to:

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# Alternative Care—A Defining Moment in Health Care

by Lee Eric Launer

There is significant activity within the health care environment in the “alternative care” field. Actually, alternative care has been around for centuries. Although there is no formal, standardized definition of alternative care, it is loosely defined as health services and treatments that are “unconventional” within the array of medical diagnostic and treatment procedures.

Treatments include chiropractic care, homeopathy, herbalism, oriental medicine, acupuncture, massage therapy, and nutritional counseling. Further, there are some experts who include certain other

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*“There is a reasonable amount of information, some of it anecdotal, indicating that alternative care techniques are able to maintain health and prevent illness very effectively.”*

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“treatments” such as energy medicine, color therapy, prayer, crystals, light work, and hypnosis. Alternative care is also referred to as unconventional, complementary, or integrative care.

There is a reasonable amount of information, some of it anecdotal, indicating that alternative care techniques are able to maintain health and prevent illness very effectively. Also, where an ailment or illness does exist, there is information that such techniques produce favorable outcomes, at a modest cost, with excellent patient satisfaction.

Further, many experts believe that alternative care should be used in conjunction with conventional medical care techniques to produce the most effective care. In fact, the model that is considered by many to be ideal is a synergy of conventional and alternative care called “integrative care.”

This article describes a few areas, including:

- Fundamental themes of alternative or integrative care
- Demand in the marketplace
- Recent activity
- Developing an alternative care program

- Actuarial concepts and data.

## Fundamental Themes

There are some fundamental themes upon which alternative care is built, including:

- **Holistic Nature of Care.** “Holistic” is defined as “whole,” meaning that it encompasses *all* aspects of an individual, including mind, body, soul and spirit. Most often, an alternative care practitioner will spend an hour or more at the first visit, or even subsequent visits, to understand all aspects of a person. The essence of holistic care is to treat the person as a whole with the person also being responsible in determining their course of treatment.

- **Prevention and Wellness.** Alternative care strongly emphasizes preventative

care and therefore relies on encouraging patients to live health focused lifestyles, including sound living with respect to diet, exercise, environment, drugs, and avocations. The practitioner strongly believes that this type of lifestyle can prevent or delay certain diseases. In this regard, vitamins, minerals and other elements thought to boost the immune system are usually part of a wellness regime.

- **Self Care.** Alternative care also teaches the individual to care for themselves, where appropriate. Self care stresses education, encouraging the individual to understand his or her health and promote well-being. Further, making conscious decisions to promote all aspects of healthy living is encouraged.

- **Natural Procedures.** Alternative care also promotes the use of ingredients from nature as opposed to pharmacology. Clearly, there are many important drugs that may be used at the appropriate time. However, alternative care encourages the use of natural agents to the extent possible.

- **Spirituality.** Another important theme is a person’s spirituality and holiness. While not trying to preach religion per se, there is encouragement to pray, believe in God and have faith. There is, again, anecdotal information that such belief is very beneficial to maintaining health and healing.

In effect, alternative care is based on a holistic model that uses natural processes with strong reliance on self care, prevention and wellness, built around a system with strong belief and faith in God and oneself.

## Marketplace Demand

Alternative-care techniques are in use, and are in strong demand, by Americans, as well as by many people in various areas of the world, including the Orient, India, and Cuba. In a quintessential study, a Harvard Professor, Dr. David Eisenberg, researched the American public in 1991 and determined the following:

- 60% of Americans use some form of alternative care
- 30% of Americans use alternative care on a consistent basis
- Americans spent roughly \$14 billion in 1991 on such techniques
- Most of the \$14 billion was out-of-pocket, since insurance programs generally do not cover these services
- Surprisingly, almost all of those individuals who use the services also use conventional care. Furthermore, the vast majority of the patients *never* tell their “conventional” doctor.

The study was to be performed again in 1997, with every indication that the demand has significantly increased.

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The study indicated that one of the main reasons for such demand is that alternative care (in conjunction with conventional care) produces lower costs, better patient outcomes, and higher satisfaction than conventional care only.

### Recent Activity

There is significant activity in the overall health-care marketplace related to alternative care practices. This includes such items as:

- Health systems, insurers, and HMOs, developing alternative or integrative care programs
- Hospitals or academic medical centers providing a range of limited to extensive services related to alternative care
- Grants and research performed to test the efficacy of specified treatments
- SOA studying costs and outcomes related to alternative care
- Literature, books, and periodicals are being written in significant numbers.

### Health Systems

There are a number of health systems (loosely defined as any insurer, HMO or general health care facility) that provide (and sometimes insure) such practices as chiropractic care, herbs, homeopathy, massage therapy, nutritional counseling, and acupuncture.

As might be expected, a wide range of programs is covered, including everything from a full array of services, to a few isolated services, to programs where there is merely access to discounted services. In other words, one large insurer provides access (through a chain of stores) to vitamins, minerals, and other nutritional supplements, on a discounted basis, but does *not* cover or insure these services within the plan.

Also, numerous "alternative care" centers are emerging. Again, there is a wide variation in programs, costs, access, and quality. As an example, there is one center in Chicago that houses virtually all types of alternative physicians, practitioners, and services under one roof. The member initially sees a physician "generalist" who directs the member to the appropriate practitioner or service. Accordingly, one could be directed to a massage therapist, herbalist, nutritional counselor, or, in certain cases, to a conventional physician or a hospital. On the

other extreme, "wellness centers" that forming under the umbrella of alternative care that provide what are essentially workout facilities with access to materials such as vitamins.

Overall, there is clearly a growing trend for insurers to cover and insure at least certain alternative therapies and to combine these with conventional care.

### Hospitals

A number of hospitals and medical centers combine their basic conventional medical services with alternative care. Again, the number and types of services offered vary widely. One hospital, in Connecticut, combines a state-of-the-art medical and surgical facility with numerous alternative care practices, including acupuncture, massage, meditation, vegetarian cuisine, and a comprehensive library on all these techniques. The hospital promotes this by the environment in the hospital. For example, meditation is available on the television in a patient's room.

### Grants, Research, and Education

There have been significant amounts of money granted that are utilized to research alternative care. Currently, the National Institutes of Health has allocated \$10 million to research chiropractic care and acupuncture. This research is being performed at a few selected facilities including Harvard and Stanford Medical Centers. In addition, there are a number of facilities that teach alternative care. As an example, Dr. Eisenberg of Harvard directs Beth Israel's center for alternative medicine, which provides numerous classes for both conventional and alternative practitioners.

### Society of Actuaries

A new SOA study has begun to capture and analyze data on alternative care. I am the Chairperson of the committee and Dr. David Eisenberg is on the Board. The committee comprises five physicians and five actuaries. They will study existing data as well as data to be captured in the future to determine utilization, costs, mortality, and other health care information for those individuals who use alternative care.

### Developing an Alternative Care Program

The development of a conventional insurance program with a provider network is

a well-established procedure. Over the past 10 to 15 years, numerous insurers, HMOs, and health systems have established such programs including the development of plan designs, utilization review programs, quality assurance techniques, and provider networks. Developing a program for alternative care providers is similar in concept, yet more difficult in many ways. The challenges range from finding a sufficient number of qualified providers, credentialing them, determining fair reimbursement, building quality assurance programs, and determining utilization and quality techniques related to alternative care.

Significant effort is sometimes required to form an alternative care or integrative care program. Some health systems or insurers have spent millions of dollars and taken over two years to implement programs. One reason for the significant effort is the lack of a precedent or an accepted road map. Some of the key tasks in developing an alternative or integrative insurance program are:

- Determining the scope of covered benefits
- Developing the provider network
- Establishing clinical credentialing criteria
- Determining a fee schedule
- Establishing quality assurance and utilization review programs
- Developing a plan design
- Actuarial pricing and modeling
- Computer system adaptation and data requirements.

### Actuarial Concepts and Data

An actuary often needs to develop results from limited information. This skill was never more appropriate than for alternative care pricing. Some information is available, yet much of it is anecdotal; furthermore, the data that are available are often not in an appropriate format for actuarial use.

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## Alternative Care

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### Basic Actuarial Pricing

Virtually all forms of actuarial pricing determine the expected cost of a health care program based upon some form of historical data. In some situations, the data can be very detailed and, in others, summary level. Yet in either case, the analysis starts with experience. Even with start-up HMOs, the pricing is based on data from a similar type of program or, at a minimum, some published table related to a compilation of others' experience. Most actuaries believe that future costs are best estimated by modifying, adjusting, and trending some form of existing experience.

The "conventional" HMO premium analysis first delineates the services that an HMO will perform (for example, a physician visit, a laboratory service, or an inpatient hospital admission). For each such service, the actuary develops "utilization" assumptions (the average number of times a member would be expected to utilize that service in a year) and "cost" assumptions (the average cost for that service). Consider physician visits as a simplified example. If it is assumed that there will be, on average, three visits per member per year, and each visit will be \$120 per visit, the HMO should expect a cost of \$360 per member per year (\$30 per member per month, as it is usually expensed). This same analysis is performed for all services and then summed to develop a total cost.

In order for the actuary to estimate the utilization specifically and to some degree cost, a historical perspective with actual experience is important. The actuary will often use this actual historical experience as the estimated number in the future. At a minimum, it serves as a base from which the actuary can make other assumptions.

### Alternative Care Pricing

The ability to get historical experience for alternative care is quite limited. As noted above, there are very little utilization data. While there are some cost data, availability varies quite dramatically by region, by practitioner, and by modality.

Another difficulty is that the types of services, scope of services and specific procedures within a scope are not clearly defined. For example, "conventional" practitioners have built up a history and developed nomenclature and related procedure codes. Comparable identifying features do not generally exist for alterna-

tive care procedures. Accordingly, the "simple" task of merely identifying all the services is much more challenging with respect to alternative care.

### Actuarial Techniques

Even with all of the uncertainty, there are still actuarial techniques that can be used to develop pricing; however, these techniques could produce numbers that vary within a reasonable range from the actual results. It would be expected that over time data will be captured to enhance the pricing techniques.

As noted above, there is a committee of the SOA with the long-term goal of capturing and analyzing data on alternative and integrative care. The committee will continually update such data so actuaries have access to data in order to price a plan.

The following describes some possible techniques that can be used currently to develop estimated costs for alternative care plans:

- *Use existing conventional data.* Use existing utilization and cost data for conventional care and apply adjustment factors for alternative care. Clearly, such factors need to be evaluated carefully, and modeling and sensitivity analyses need to be performed. This method has been used in a few situations and *seems* to produce reasonable results. Yet follow-up analyses in succeeding years are critical.
- *Develop data from discussions with providers.* In other situations, it is possible to visit or call a cross-section of alternative care providers and practitioners to discuss patterns of use, as well as their cost structure. In most cases, providers can give you cost information and estimated utilization data that they have accumulated (or more often raw data that you must analyze). Again, this method should include sensitivity modeling.

This method is not precise, but certainly gives some basis for developing rates.

- *Use a competitive premium method.* In some cases, premium rates can be developed based on competitive premium information. Utilization assumptions and costs are developed that can support those premiums. In

fact, this method can be an indirect way to set a fee schedule for alternative care.

Further, this can lead to the development of utilization review techniques, plan maxima or even capitation rates. Such methods will "force" providers to meet patterns that will support the premiums.

For any of these methods, the level of profit, administrative expense, margin, and any other conservatism must be determined. The level of margin will probably be greater for alternative care pricing than conventional care, but should be contingent upon the method, data, and information that was available to the actuary.

An important question for health systems that offer a variety of plans including integrative and conventional care is the level of premium for an integrative care plan *in relation* to the conventional care premium. This question is significant. In theory, an integrative plan that combines conventional and alternative care should be *less* than a conventional premium. Alternative care should be able to keep people healthier, and when care is needed, the patient is directed to either conventional care (the services they would usually receive anyway) or alternative care (where the service is presumably less expensive and may produce better outcomes) instead of conventional care. Furthermore, in those cases where both conventional and alternative care are used, this should speed recovery and hasten healing. Therefore, one could argue that integrative care premiums should be lower than a conventional plan premium.

However, before utilization and actual experience of these plans are known, HMOs may have difficulty pricing in this manner because of profitability concerns. Therefore, the early plans have been priced at higher levels, or as riders and add-on costs. We will watch with interest as to what develops over the next few years.

### Miscellaneous

There has been some controversy and probably some misunderstanding

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between conventional and alternative practitioners. To some degree this is based on misunderstanding and to some degree on clinical disagreements. This article does not address this conflict. Yet, suffice it to say, that while there are real differences, it is believed that these disagreements appear to be narrowing as more information is disseminated.



Overall, it is expected that the use and demand of alternative care will continue to rise and that health systems will continue to develop such programs to meet their customer's needs. Further it is expected, that clinical and actuarial research will continue unabated and lead to even more demand. Finally, it is expected that continued education will lead to better understanding by conventional providers.

*Lee Eric Launer, FSA, is an actuary and partner at The Kwasha Lipton Group of Coopers & Lybrand in New York, New York and a member of the Health Section Council.*

**DSIG Seeks New Blood**

The Disability Special Interest Group (DSIG) is looking for volunteers. The DSIG was founded in 1994 as a subsection of the Health Section to address the following objectives:

- To provide a leadership role in organizing effective SOA meetings for individual and group disability income actuaries
- To develop and maintain a database of disability-related information on the SOA web site
- To give disability actuaries a forum for identifying and responding to important issues, such as regulatory compliance issues.

The DSIG currently has more than 400 members. We are looking for volunteers for a new chairperson to replace Tom Corcoran, who is resigning to focus on his duties as chairperson of the Health Section. We are also looking for volunteers to work on developing online databases, a function previously performed by Mike Lachance.

For further information, please contact Tom Corcoran at: phone, (860) 843-7094; fax, (860) 843-7099; or e-mail, [corcort@tillinghast.com](mailto:corcort@tillinghast.com).

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An order form is included with this issue.