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GROUP PRICING, PRODUCT, AND MARKETING ADAPTATIONS TO AN INFLATIONARY ECONOMY

A discussion of the actuarial techniques required to combat the impact of inflation on both Group Life and Health insurance, including possible increases in premium rates and how to communicate these to clients. The introduction of new national or local health plans will also be considered.

MR. JAMES P. SMITH: The current trends in claim costs of Group Life and Health Insurance products arise from a mixture of inflation, recession, consumerism, changing morality (for want of a better word), and education about policy benefits. The actuary is faced with the need to adjust premiums and dividends (rate credits) to reflect the expected composite effect of all these causes, and to work with Company staff to respond to policyholders' needs for ways to cushion their finances from the impact of claim costs. We need to recognize claim trends and some of the ways currently in use to compensate for them. I'll speak in turn about Group Life, Health, LTD and Dental Insurance.

The average Group Life claim is increasing rapidly. The causes are the compounding effect of inflation on the heavy swing in recent years to Salary Schedules, and the increasing interest in full use of the tax advantages of Group Life Insurance. The actuary has responded to this trend by increasing emphasis on pooling amounts of insurance in excess of some limit, such as $25,000. Brokers and policyholders have accepted pooling quite readily -- almost as if they are saying "Thanks for putting insurance back into Group Life Insurance."

Waiver of Premium has leaped into prominence as benefit amounts have risen. Policyholders and brokers are very interested in the amount of Waiver reserve carried by companies and in possible interest earnings on such reserves. Some policyholders seek to continue paying premiums on disabled lives without reporting them as eligible claimants so that their insurers do not reduce dividends by establishing reserves. The actuary seeking correct Life experience figures should have his claim records audited to determine if they contain fewer Waiver claims than expected.

The more straightforward approach is to substitute Scheduled Waiver (i.e., benefit decreases during disability at the same ages that benefit of an active life would decrease) or No Waiver for Full Waiver (i.e., disabled benefit frozen for life at amount of insurance in force at date of disability). We believe the actuary should increase his Incurred But Not Reported (IBNR) for reduced or eliminated Waiver Benefits and, of course, we can reflect the lower risk in lower premium rates. However, the actuary of a take-over carrier must furnish guidance to his underwriters on rules and rates to be used when accepting a risk previously insured on a No Waiver basis for it is to be expected that the policyholder will want coverage for his disabled, not-at-work employees, Incidentally, our underwriters strongly urge contributory No Waiver policyholders to pick up the employee contributions during such sick leaves.

Some trace the current pressure on Group Life rates to the recent repeal of New York minimum rates but I truly believe the trend toward lower rates began before that. We note that, since 1970, our average Group Life annual premium

per $1,000 has dropped from $6.80 to $5.07, or 25 percent. Some of the reduction is a reflection of cases with lower average age and higher female content but a good deal of the reduction is the result of lowered basic rate structures. Today, large policyholders often seek rates which are discounted, sometimes below expected claim costs, but, in return, the policyholder is willing to accept retroactive premium adjustments to the extent that charged rates are discounted from normal rates. The actuary must keep his wits about him to get an adequate retention out of the reduced rate and should be careful about paying the proper premium tax in states that do not give credit for dividends.

My final comment about Group Life is the fact that many bid specifications ask for sixty or ninety day grace periods. The actuary must be careful to charge for such service in his rates and retention and must be sure that underwriters accept only good credit risks for such extensions.

In the Group Health area, the first thought that comes to mind when considering the current economic scene is trend in medical care costs. From all measures we have seen, the upward trend is not as steep as it has been. Our current standard renewal annual trend and utilization-increase factors are 9.5% and 1.5%, respectively. Unlike some carriers, we've not varied these factors. These trend, utilization and area factors must be monitored continually. Too low can mean inadequate rates, too high can mean non-competitive rates.

In our Company, we have seen a considerable decline in resistance to Group Health rate increases resulting from trend and utilization projections. Replacing discussions about trend are discussions about size of, and the necessity for, reserves on Group Health. The broker and the policyholder's interest in reserves may range all the way from questioning the size of a reserve, through questioning the need for it, to consideration of possibilities that the reserve serves the policyholder best if invested in his business. The latter thought brings out consideration of self-insurance. ERISA has also increased the number of such discussions because it prohibits the states from charging an employer with illegally engaging in the business of insurance solely because of the employer self-insuring his health benefits plan. The actuary whose company will service self-insured type contracts has an interesting task in pricing the specific services that will be performed. He can also get into the task of pricing Stop Loss or Excess Risk coverage for the self-insured plan. The actuary whose company resists or refuses to service self-insured plans has to be very sure that his rate, retention, and reserve formulas will all stand close scrutiny.

The policyholder that remains insured wants to be sure that his premium dollars are used efficiently. As a result, discounted or deviated premiums are of interest to Group Health policyholders, as they are to Group Life policyholders. The same considerations are required of the actuary. Another corollary with Group Life is the interest in extended grace periods. Comment: It is wise to audit the loss your company may be experiencing from late premium payors who regularly violate grace periods. The privilege of an extended grace period should be specifically granted and a charge made for it. It should not be given free to financially-risky policyholders.

An aspect of today's Group Health business that is not related directly to the economy is the pressure for policyholders who are changing carriers for no-loss/no-gain consideration. This is particularly difficult to grant on small groups. It costs money to waive preexisting conditions, exclusions, and actively-at-work clauses. The rate considerations of the actuary for such take-over situations must be carefully related to the care with which the underwriters approve take-over cases.

The benefit structure of most Group Health plans being sold today is gen-

erally adequate. The one benefit area resisted when separately priced at its proper level is the high Major Medical limit. A popular, modern benefit area is the limit on out-of-pocket expense per Major Medical benefit year and there has been little question over the price of it.

LTD rating for white-collar groups has become more realistic. Policyholders accept adequate rate levels though there is a good demand for rate guarantees. LTD for non-office employees has always been a rating problem. With unemployment levels up, non-office employee LTD will be much harder to rate. Our LTD book has been remarkably stable. We have avoided what is commonly known as the "blue-collar" risk. Perhaps our most vulnerable occupational groups are school groups which face declining staff requirements. But, so far, our LTD is profitable.

In LTD, the state of the economy is reflected in benefit demands. There is great pressure for higher maximum benefits, for less integration with other income, and for frozen benefits on disabled lives. All can easily be underrated if the actuary is blind to the overinsurance these benefits can provide in a different economy. Much more difficult to rate are no-loss/no-gain take-overs, elimination of preexisting-conditions provisions and elimination of actively-at-work provisions, all of which are related more to consumerism than the state of the economy.

As with Group Health, the policyholder and brokers are very interested in LTD reserve levels and interest credits on reserves. To gain the use of LTD reserves, we hear a lot of talk about ASO LTD and 501(c)9 LTD. One approach is the use of self-funding for the first five years of benefit, insuring only payments after five years. The actuary pricing this type of product will need extreme confidence that his continuance table is appropriate for a five-year elimination period and he will need to consider carefully the claim-paying philosophy used during the elimination period. Note the effect on claims when salary is paid during an elimination period as shown in Table 5A, Page 292 of the 1973 Reports.

We see no trends of consequence in Weekly Income. In Dental, the popular product is Reasonable and Customary, probably because Scheduled Plan benefits have not kept pace with inflation.

There are three major trends that overshadow all of the foregoing and the actuary must cope with them. They are all consumer-oriented. First is "maternity same as any other," which drastically changes claim ratios. I know of one company faced with an extreme amount of pressure from a State Agency to give this benefit immediately to all of its Group Health policyholders without increase in premium until next plan anniversary and without allowing the policyholders to dissent.

Second, a growing number of states are mandating minimum benefits, recognition of all types of practitioners, coverage from birth, extension of coverage during disability, extension of coverage to dependents of deceased employees, extension of coverage to terminated employees, minimum benefits for mentally disturbed, special benefits for alcoholics, etc. The rating effect of most of these depends on the type of plan in force and the extra-territorial effect of the laws.

Finally, and probably most disturbing to the actuary, is the increasing number of punitive damage claims. My Company has always prided itself on being extremely fair on claim payments, yet we picked up four punitive damage claims ranging from $500,000 to $1,000,000 in one recent month, after years without any such claims. We believe that consumerism may be involved to some degree but put most of the blame for this increase in punitive damage claims on a changing morality. Regardless of cause, the actuary must start considering additional risk charges for punitive damage claim possibility in all premium rates.

MR. HOWARD J. BOLNICK: Both inflation and recession can cause an increase in claims on group medical expense and income replacement coverages. The question that we will discuss is the effect that increased claims have on the profitability of various group experience rating plans. Although inflation and recession do affect claims, an increase in claims may not affect profits.

Group carriers issue three basic plans: 1) prospective experience-rated plans, 2) retrospective experience-rated plans, and 3) combination prospective and retrospective experience-rated plans. Each of these plans will be discussed in turn. For each, we will identify the major risk to the carrier caused by predicted increases in claims and by unpredicted increases in claims. For those plans where an extra risk does exist, we suggest methods to eliminate or decrease the effect on profits.

I. PROSPECTIVE PLANS

A prospective plan uses actual past claims and expected future claims to project a premium for the next experience period. Nonparticipating small group cases utilize a prospective plan as do certain intermediate and large group cases where experience refunds are not paid.

Prospective plans are pure insurance plans. Gains from one case are used to offset losses from another case. This risk-sharing characteristic is true whether the prospective formula is used at the case level or at the portfolio level.

The major risk associated with a prospective plan is that an unpredicted rise in claims may cause claims to exceed premiums. Since gains from one case are used to offset losses from other cases, this will occur only when aggregate claims for all prospective cases exceed aggregate premiums for those cases.

If a large loss is suffered by a carrier, future case termination may become a mild additional risk. This risk is increased if the carrier attempts to recover current losses by increasing future premiums in excess of the requirement to cover future claims. By spreading one year's loss over a period of years, a large premium increase should not be necessary. Minimizing premium increases will minimize the termination risk.

Various methods are available to the carrier to minimize the risk of profit deterioration on prospective plans. Foremost, but most difficult in practice, is proper prediction of the effect of inflation and recession on claims. Many companies have developed sophisticated techniques to monitor medical price rises and to reflect the increases in premium. To avoid the unfavorable effects of unpredicted claims, two techniques are available. First, the premium can include a large margin for claims to allow for erroneous predictions. Second, the period over which the premium is fixed can be reduced. As an example, some carriers have gone from the usual annual review to a monthly review of premiums.

Profit deterioration on prospective plans due to the effects of inflation and recession comes only when claims are not adequately predicted. Properly predicted, inflation and recession will not affect profit.

II. RETROSPECTIVE PLANS

A retrospective plan requires an initial premium containing a large margin for claims with an experience refund of the excess of the initial premium over actual claims to be paid at the end of the experience period. Retrospective plans can be used with a portfolio of small, intermediate, or large cases. I know of no carriers currently using a true retrospective plan, al-

though these plans were quite popular with mutual carriers before World War II.

Retrospective plans are pure insurance plans. Gains from one case are used to offset losses, if any, from other cases through reduced experience refunds. This characteristic is true whether the retrospective formula is used at the case level or at the portfolio level.

The risk that premiums will not be adequate to absorb an unpredicted increase in claims is minimal. The few losses that do occur can easily be recovered through a small reduction in experience refunds on those cases with gains. The only real danger arises when unpredicted claims are so great that a large reduction in experience refunds is necessary.

A mild case termination risk is possible if experience refunds are drastically reduced. By spreading one year's loss over a period of years, though, a drastic reduction in experience refunds should not be necessary.

Despite the large margin for error inherent in the initial premium, carriers using retrospective plans should take precaution to insure that no drastic reductions in experience refunds become necessary. First, as predicted increases in claims become apparent, an increase in premium should be required to maintain a substantial margin for claims. Second, the risk of grossly underpredicting claims can be minimized by shortening the experience period.

Retrospective plans offer substantial safeguards to the carrier against escalating claims due to both predicted and unpredicted effects of inflation and recession. Unfortunately, no carrier has designed an attractive plan, although I feel this could be done.

III. COMBINATION PROSPECTIVE AND RETROSPECTIVE PLANS

Combination prospective and retrospective plans are offered on a carrier's largest cases or for a large pool of small participating cases. The risk that we are interested in is the large case. At the beginning of an experience period, a prospective formula is used to determine the premium with only a small margin for claims. At the end of the experience period, a retrospective formula is used to refund the excess of premium over actual claims.

Except for stop-loss pools that may be associated with large cases, no risk sharing occurs between cases. Gains from one case are returned to that case, while losses from another case are carried forward to be recovered from future gains from that same case. As long as a case remains active with the carrier, it should eventually pay its own claims. In years when claims do exceed the premium, the carrier's annual statement shows a loss; but, if the case stays active and the loss is recovered from future premiums, a corresponding gain will emerge on a future annual statement. This, of course, means that the carrier's long-term profit is not impaired by unpredicted increases in claims. The major risk to the carrier on combination plans is that a case will have a losing year and terminate the contract, leaving an unrecoverable loss. This type of termination risk is not insurable because of the obvious antiselection inherent in allowing a case the privilege of unrestricted termination. Without the ability to pool or "insure" either the claims risk or the termination risk, the characteristics of a combination plan more closely resemble a flawed financing arrangement rather than an insurance contract.

There are a number of methods of eliminating the termination risk assumed by the carrier. First, though, the carrier and its client must reach an understanding that there is not an "insurance" contract between the two parties. The existing contract is for administrative services (that is, claims payment, plan design, actuarial services, etc.) and a financing arrangement to help

smooth out fluctuations in claims. Once such an understanding is reached, alternatives to the traditional group contract can be proposed to maintain the administrative services, and, where necessary, the financing arrangement, while eliminating the carrier's termination risk. Some examples of possible contracts between the carrier and the client include:

1. An Administrative Services Only contract with supplemental stop-loss coverage -- The ASO agreement provides administrative services to the client while the stop-loss coverage protects the case, on a pure insurance basis, from claim fluctuations. The carrier, though, must carefully assess the effects of inflation and recession on the stop-loss pool.
2. Retroactive premium agreements -- If unpredicted claims affect the case, an agreement can be entered into which totally reimburses the carrier for excess claims.
3. Cost-plus contracts or minimum premium agreements -- A premium deposit is accepted by the carrier, at the beginning of the experience period. Any excess of claims over the premium deposit is then due at the end of the experience period.
4. Termination clauses -- A clause is added to the traditional contract making any unrecovered losses payable upon termination of the contract. The only remaining problem is sound financing of losses while the case is active.

The number of contracts that can be developed is limited only by the imagination of the actuary.

If a risk-free contract cannot be written, the carrier has a number of techniques available within the traditional contract to reduce losses and thereby reduce the risk of case termination. Deficit management techniques include:

1. Use an overall claim and/or an individual claim stop-loss pool -- Taking a risk from the experience-rated portion of a case and creating a true insurance pool for the risk decreases the potential loss.
2. Build up a contingency reserve -- An existing contingency reserve is as useful as a higher initial premium when unpredicted claims occur. A high enough contingency reserve may even approach the value of a retrospective plan in reducing the risk of loss.
3. Provide a higher premium margin for claims -- The benefit of this technique is to allow a margin for unpredicted claims.
4. Require a partial retroactive premium adjustment -- Any contractual recovery of a loss is helpful, even a less-than-total recovery.

Deficit management techniques can reduce, but not eliminate, the termination risk on combination plans.

Properly handled, combination plans offer the carrier the least risk and the steadiest profit of any experience rating plan. Improperly handled, though, the effects of inflation and recession on combination plans offer the most subtle and potentially damaging risks to an insurance company's entire portfolio.

IV. CONCLUSION

It is important to recognize that, by themselves, inflation and recession are not harmful. Properly predicted and accounted for in premiums, extra claims resulting from inflation and recession will not affect profit on any of the three basic experience-rating plans. Unpredicted extra claims are the sole

cause of profit deterioration, but they affect each experience-rating plan to a different degree. Prospective plans are directly affected by unpredicted claims. Retrospective plans will not be affected unless claims are grossly underpredicted. Combination plans will have their profit affected only to the extent that unpredicted claims are the ultimate cause of a case terminating with unrecovered losses. Thus, the type of experience-rating plan used by a group carrier can play a significant role in the carrier's exposure to the effects of inflation and recession on profit.

MR. WILLIAM CUNNINGHAM: My part of this panel presentation will deal with communication to our clients -- in particular, how do you present increases in premium rates. I am taking the liberty of making the following assumptions:

1. All communications will be through your group representative, the agent of record, and finally to the policyholder; and
2. All parties are reasonable people. As we often learn when a case cancels with a deficit, this is not always true. No company can eliminate dealing with unreasonable people, but sound initial underwriting can minimize the problem, and your group representative has to be your first line of defense. Proper training and compensation will determine your success.

The public is well aware of the medical inflationary spiral and, as mentioned previously, accept trend and utilization factors. This makes selling rate increases easier even though they always hope for less than requested. The industry is more realistic in its pricing; and, thus, comparison shopping appears more favorable to the in-force carrier than was the case 10 to 15 years ago. Our approach is along the following line:

1. Visual aids will be used. Below are several types of visual presentations that we can make available. Obviously, they are all not used on any one case; and, in many instances, none are presented due to the adverse manner in which they might be used.
2. Modifications in the benefit structure may be recommended.

I. VISUAL AIDS

We review published medical indexes but use them only for smaller cases to indicate general trends and substantiate the need for rate increases. The important item for any presentation is a survey of the charges made by hospitals in the policyholder's community. Our benefits department keeps our group representative up to date on semi-private charges in each community. We used to publish this data but have stopped doing this due to the frequent changes. Table 1 is a quarterly report that we furnish on major accounts. The original purpose was to keep our policyholders informed as to the adequacy of their plan benefits. We have expanded this report to include Figures 1 and 2. At a glance, the policyholder can be informed of expected charges, current charges, and past trend lines. This simplifies our explanation of trend lines and the need for higher premium rates, which in some instances have been greater than could be justified on national or local averages.

The case used has had no unusual economic fluctuations. Figure 3 demonstrates a case that has had unusual economic fluctuations; and you will note that between 1971 and 1972, there was a 50% drop in size with a 50% increase in incurred medical claims per insured employee. It was impossible to determine how much was due to (a) inflation, (b) change in risk (age-sex mix), or (c) selection. The employer projected a rapid increase in his employment

TABLE 1

GROUP MEDICAL CLAIMS REPORT FOR QUARTER ENDING JUNE 30 1974

4188 MEMOS
PROCESSED
2300 DAYS
HOSPITAL

DEPENDENT

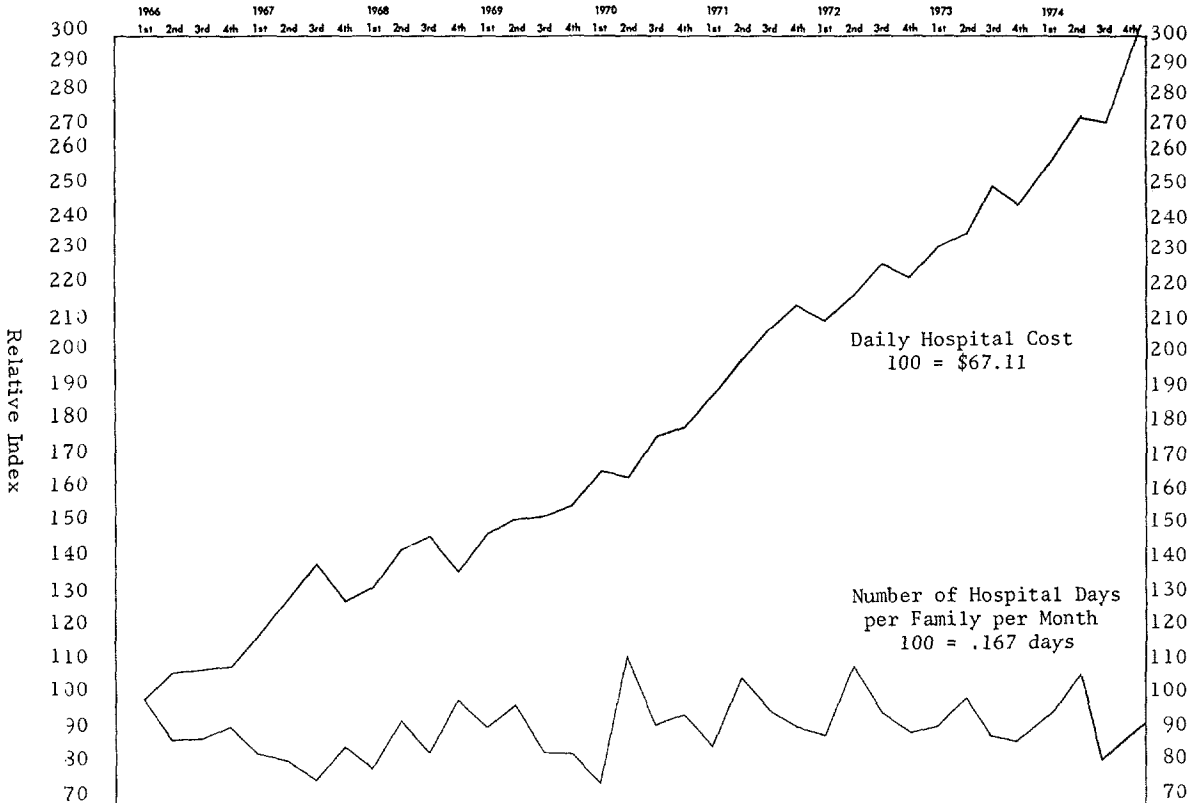
BENEFIT	RECOGNIZED EXPENSES	BASIC ELIGIBLE	MAJOR ELIGIBLE	MATERNITY	TOTAL
HOSP. D.S.C.	188 319.85	160 752.20	183 563.95		
HOSP. EXTRAS	213 929.13	176 907.57	211 366.01		
SURGICAL	153 039.64	104 501.74	140 088.64		
MEDICAL CARE	128 105.63	.00	107 345.31		
DIAGNOSTIC	60 080.41	.00	55 029.86		
P. A. N.	51 183.57	.00	50 168.61		
OTHER	.00	31 651.48	.00		
TOTAL	794 658.23	473 812.99	747 562.38	14 244.98	
STAT. INS.		36.00	.00		
BALANCE		473 776.99	747 562.38	14 244.98	
OTHER INS.			.00		
BASIC BEN.			457 999.97		
CASH DEDUCT.		.00	61 605.87	.00	
CO-INSURANCE			42 407.28		
ADJUSTMENT		48 018.15-	19 570.63-	150.00-	
TOTAL PAID		425 758.84	165 978.63	14 094.98	605 832.45
% OF RECOG.		53.58	20.89		

JANUARY 1974 THROUGH JUNE 1974

BENEFIT	RECOGNIZED EXPENSES	BASIC ELIGIBLE	MAJOR ELIGIBLE	MATERNITY	TOTAL
HOSP. D.S.C.	316 060.45	267 948.90	306 029.35		
HOSP. EXTRAS	384 042.97	292 592.05	379 101.02		
SURGICAL	270 955.71	173 373.39	241 531.67		
MEDICAL CARE	217 639.53	.00	153 898.56		
DIAGNOSTIC	107 336.42	.00	101 938.62		
P. A. N.	103 269.65	.00	101 228.74		
OTHER	.00	55 786.93	.00		
TOTAL	1 399 304.73	789 701.27	1 323 727.96	21 217.43	
STAT. INS.		240.00	.00		
BALANCE		789 461.27	1 323 727.96	21 217.43	
OTHER INS.			.00		
BASIC BEN.			773 111.59		
CASH DEDUCT.		.00	101 682.55	.00	
CO-INSURANCE			86 321.42		
ADJUSTMENT		87 846.75-	44 165.58-	338.93-	
TOTAL PAID		701 614.52	318 446.82	20 878.50	1 040 939.84
% OF RECOG.		50.14	22.76		

MATERNITY CLAIMS SHOWN ARE NOT INCLUDED IN OTHER ACCUMULATIONS

FIGURE 1 - Recognized Hospital Expenses



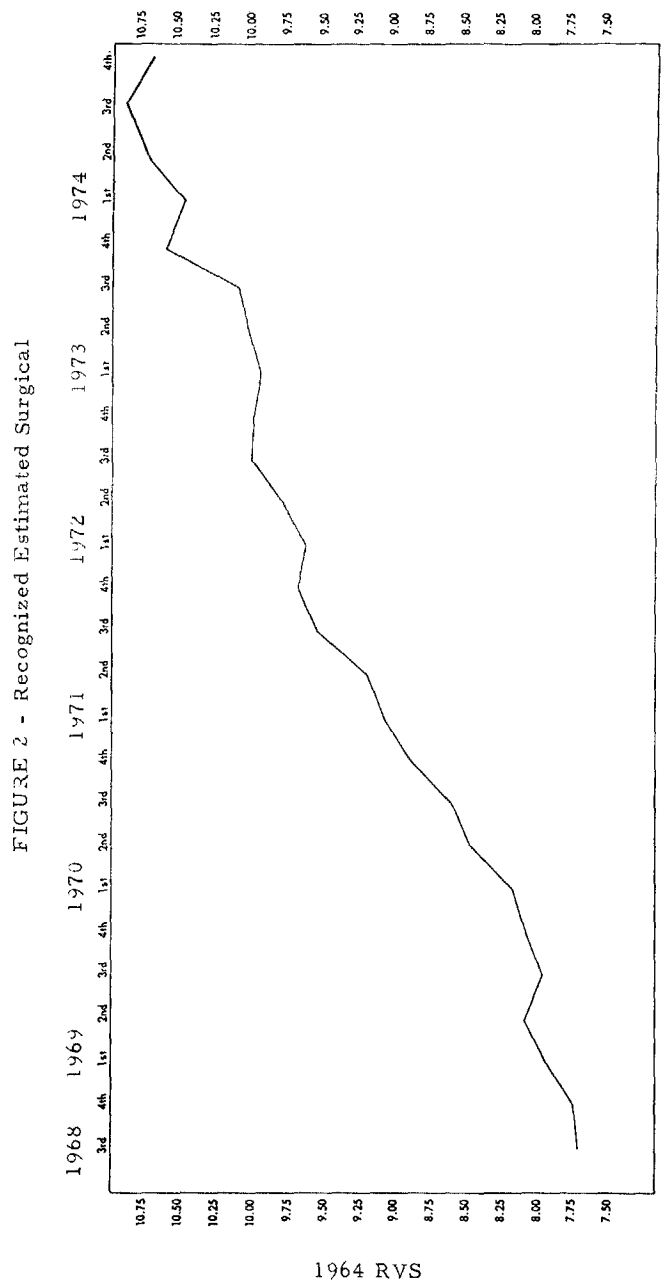
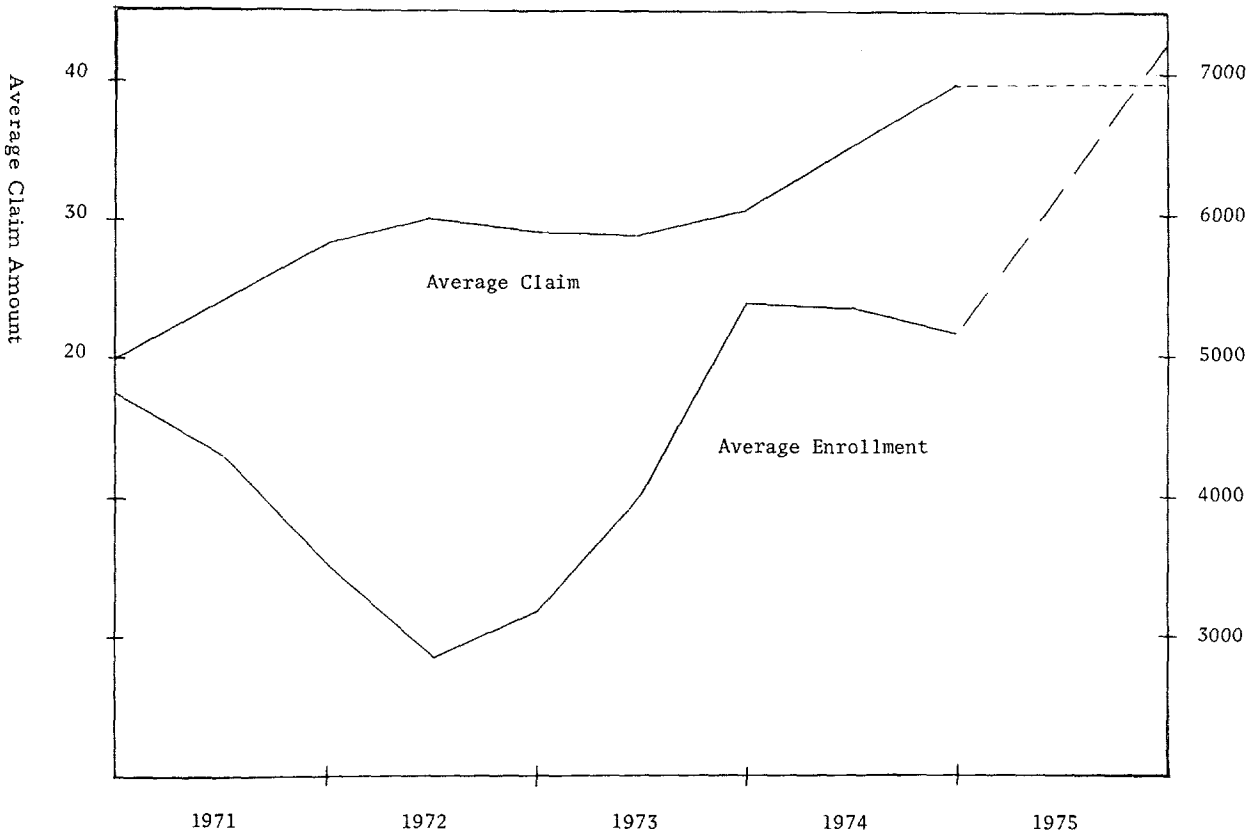


FIGURE 2 - Recognized Estimated Surgical

FIGURE 3 - Average Claim vs. Average Enrollment



level and the final solution was a six-month rate with a retroactive premium inversely graded to employment level.

Please note that the size increased over the next 18 months and claims leveled off. Another drop in size in 1974 was accompanied by another spiral in claims. Note how we tried to predict 1975.

II. MODIFICATIONS IN BENEFIT STRUCTURE

I believe that there is general concurrence among actuaries that medical cost inflation can be contained by (a) encouragement of new technologies that economize on providers time and (b) raising the price paid by the patient. Both of these approaches are unrealistic under National Health and, while we can only encourage the former, we can do something about the latter -- without necessarily increasing the cost to the patient. My company is a strong believer in the use of limits under our policies which encourage the patient to attempt to keep costs to a minimum. We strongly support the Medical Foundation concept through the sale of foundation-approved medical plans. For example, in one California county we use a factor of $12 with the 1964 California RVS for usual and customary but are required to only pay $10 for foundation plans.

We have been successful in foundation areas experimenting with no deductible on physicians' charges and a deductible in the hospital area which encourages the use of out-of-hospital facilities. If successful, this increased use of the out-of-hospital facilities will cause a downward trend in the hospital utilization curve. We communicate these benefit modifications -- front-end hospital deductible, increased share of coinsurance, use of internal limits within the program -- to the policyholder with our prediction on what effect it will have on the inflation trend and utilization curve. Many times we join together the benefit modifications with a shorter rate guarantee period in an effort to hold the current cost to the policyholder or to significantly temper the need for any rate increase. This form of communication is well received by the intelligent policyholders as they do understand the effort on our part to assist them in holding down spiralling costs.

We support Hospital Review Programs -- encourage these in foundation plans -- and support industry efforts, the Delaware Valley Program being the latest. In summary, we believe that an informed policyholder will have confidence in us and will support our efforts to help him. This also places a burden on the insurance company to be innovative and progressive -- we should take calculated risks. My company encourages all companies to do the same; and, if successful, the threat of National Health will be lessened.

MR. STEPHEN N. STEINIG: Were the four punitive damage claims mentioned by Mr. Smith suits filed against your company or were they judgments against your company?

MR. SMITH: They are suits and we are in the process of litigation. Two suits are in California, one is in South Dakota, and one is in Minnesota.

CHAIRMAN TED L. DUNN: The Group Life Premium Waiver problem mentioned by Mr. Smith is of importance on the larger retention size case where the policyholder is interested in having the use of the funds which would otherwise be held as a reserve by the insurance carrier. If the Group Life master policy is not amended to eliminate the Premium Waiver Provision, the insurance carrier will retain the terminal liability for the Premium Waiver coverage in the event the plan terminates. If the Group Life master policy is amended to eliminate the Premium Waiver Provision and thereby provide a cash flow advan-

tage to the group policyholder, the risk of loss of coverage on a disabled employee in the event the policyholder goes bankrupt is shifted to the disabled employee. Insurance regulatory authorities need to be aware of their responsibilities to the insured population under such circumstances since an insured employee does not normally have the financial acumen to compete with his employer or the group insurance carrier for his employer.

MR. SMITH: A method that may be used to uncover Group Life Premium Waiver claims not being reported is to cross-index Group LTD claims with Group Life Insurance Premium Waiver claims where the same insurance carrier provides both coverages.

MR. J. DARRISON SILLESKY: We are equally concerned about the nonreporting of Group Life Premium Waiver claims and we have difficulty in getting cooperation from some policyholders. What disturbs me is that I'm quite convinced that many of our sales people, brokers, and consulting firms are selling this to policyholders. I would encourage all companies to go to work on this because it is a very serious risk problem, and one that is growing very rapidly.

MR. WAYNE V. ROBERTS: Mr. Smith mentioned the possibility of reducing Group Life Premium Waiver benefits at age 65 or of terminating such benefits on disabled employees if such changes are also made in the coverage for active employees attaining age 65. How much do you reduce Group Life rates for the Premium Waiver change at age 65? What is the proper claim charge instead of the normal charge of $750 per $1,000 of insurance?

MR. SMITH: Our rate differential is one or two cents. At the present time, we are not making a distinction in our claim charge but should probably do this.

CHAIRMAN DUNN: A paper entitled "Reserves for Lives Disabled under Group Insurance Extended Death Benefit Provisions of the Premium-Waiver Type" by Mr. Raymond B. Krieger was published in the 1971 Transactions of the Society which deals with this subject. Factors are given in the paper for various reduction patterns by age and duration of disability.

MR. CUNNINGHAM: We had a policyholder whose Premium Waiver claims at $750 per $1,000 of insurance were equal to its death claims. This is very high. One alternative to the usual Premium Waiver benefit is the old 12-month extension period. However, the claimant then has a right to convert at that point; and it is obvious that the conversion charge will have to be significantly higher than with normal conversions.

MR. SILLESKY: On a different subject, our December Hospital-Surgical paid claims showed a substantial rise. There was a small rise in October which dropped back in November. Pending claims at year-end were high also. January 1975 claims are less than December but still high. I know three Eastern companies have had a similar rise. Is this an oddity or the beginning of a trend?

MR. SMITH: We have seen something similar in December 1974, January 1975, and February 1975.

MR. CUNNINGHAM: Our experience is high also. One problem we have is that we feel our Diagnostic premium is currently understated by about 30%. Whether this is tied into the malpractice problem, I don't know. An investigation of

Diagnostic experience by area indicates the Gulf Coast area has had a fantastic increase in the use of such procedures in hospitals. Other areas of the country have also had an increase in Diagnostic X-Ray and Laboratory procedures.

CHAIRMAN DUNN: The number of claims has recently increased substantially in our company. A portion of this increase has been attributed to the economic situation since employees no longer seem to accumulate their claims as long but, instead, quickly file them to get their money back.

MR. CUNNINGHAM: Let's look at a piece of non-par business with a policy year running from July 1 to July 1 and assume inflation is 12% annually or 1% per month. Thus, if the average claim level is 100, the claim level is 94 on July 1 and 106 at the end of the policy year. From July 1 to December 31, the average claim will be 97 and during the second six months, it will average 103. For statutory reserving on December 31, should you not establish a contingency reserve liability for the higher level of claims expected in the second half of the policy year ending on July 1? Our company did establish such a reserve at the end of 1974 because otherwise you are taking profits that aren't really there. Have other companies done this?

MR. SMITH: Our company did not do this but it is a good idea.

MR. BOLNICK: Our company did not do this.

CHAIRMAN DUNN: An item of current interest is the problem of providing benefits for unemployed or laid-off people who are about to lose or have already lost their group insurance benefits. Is the Federal Government going to tell us what to do or should we exert some influence in deciding what should be done?

MR. SMITH: There is an industry committee that is working on this problem. This committee is trying to obtain emergency legislation operative by July 1, 1975 that will provide a type of stop-gap financing. In order to get the plan started, a tentative premium arrangment is to be finalized in a retroactive fashion after it is determined who is insured. The problem is that unemployment offices' records are not usable and the committee is reluctant to add to the paperwork.

MR. CUNNINGHAM: An administrative problem is the 60-day lag between unemployment and the receipt of benefits from unemployment insurance. How do you pick up the claims in that 60-day period? There are three proposals being made: 1) Group Insurance carrier is on the risk, 2) Employer is on the risk, and 3) Government would pick it all up. Another problem is that the cost of administration will be excessive compared to the benefits.

MR. BOLNICK: How much will it cost to provide the benefits?

MR. CUNNINGHAM: The general approach is that the employer will pay the same premium to continue the same plan of benefits.

MR. SMITH: The assumption is that layoffs will occur among younger employees and, therefore, rates will not have to be increased.

CHAIRMAN DUNN: In Mr. Smith's prepared remarks, he stated that his company's current standard renewal combined trend and utilization increase factors

amounted to 11% annually. The comparable factors used at the Provident Life are somewhat higher. Effective with the elimination of price controls on May 1, 1974, we reverted to the annual trend and utilization factors in effect at the time of the Phase I Freeze in August 1971. Essentially, these factors provided for a 15% annual increase in claim cost for full-coverage medical care benefit plans. As a result of the substantial price increases by hospitals and physicians in the summer of 1974, our combined trend and utilization factors were increased by approximately one-third to a level providing for a 20% per year increase.