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MARKETING AND PRICING CONSIDERATIONS OF GROUP INSURANCE IN THE 1980's

Moderator: BERNARD J. VILLA. Panelists: CLAUDE R. LAMOUREUX, ROBERT C. BENEDICT, RICHARD BILISOLY

1. The 1960's and the 1970's
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3. The 1980's
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MR. BERNARD J. VILLA: We have assembled a panel of actuaries that have long experience in group insurance area. Their backgrounds are quite varied. They work for insurance companies that have different primary markets, and of course, we have invited a consultant to give you the consumer's point of view on group insurance in the 80's.

Our first speaker is a personal friend of mine, Claude Lamoureux. He is a graduate of Laval University in Quebec City. Metropolitan hired Claude from university to work here in our Ottawa office. Several years ago, the challenge of our corporate headquarters brought Claude to New York as a vice-president in Group Analysis and Controls. In this position he is responsible for the development and analysis of Metropolitan's expense charges, interest credits and risk charges for our entire life and health portfolio.

MR. CLAUDE R. LAMOUREUX: My comments this afternoon will be made, as Bernie alluded to, from the standpoint of an insurance company actuary. These comments, in general, are applicable to cases of all sizes, but I think they are more pertinent to medium and large cases where changes tend to occur first. Some of you may want to disagree with me on that.

In the early 60's, pricing was synonymous with the premium a life insurance company charged for either group life or group health. The actuary's problems were the adequacy of his rates, and the margin included in those rates. Later on in the same decade, retention made by an insurance company became more important. The emphases on retention and high premium taxes were the catalysts that led to minimum premium arrangements. In the 70's, most large cases were on a minimum premium basis. The client wanted low retention consistent with good service. To achieve this, that is the low retention, he was willing to consider

giving the insurer some protection in case of termination in return for lower margin and risk charges. Many customers were even willing to assume more risk themselves through administrative service arrangements. From the early 60's to the 80's the nature of the competition for insurance companies changed. Third party administrators became more active and aggressive. Self-administration became more prevalent. As a result of the changes just mentioned, insurance company actuaries became more involved in retention matters. In the area of administrative service arrangements, the actuary has to be concerned about cost accounting matters in order to help his or her employer make a profit.

In the 80's we may expect the scenario of the 70's to continue to some extent. An insurer will have more competition from self-administration or administration provided by a third party. Among these third party administrators we have already seen competition from non-traditional sources. I would expect that we will see more of it. Sources like computer software houses, and even industrial corporations, that will market their claim payment system. On the other hand, because of the cost involved in designing and maintaining a good computer system and the desire of employers to limit the proportion of their costs going to medical care, the emphasis on retention will shift with emphasis on the 95% of each employer dollar that goes to benefits. Because of this, many employers who are presently administering their own claim payment systems will take one of two options: They will transfer their responsibility to people who specialize in this area, or they will rent a computer system or buy one that will provide them not only with a good claim payment system but also, more importantly, statistical reports that will assist in spotting abusers of the plan. These abusers include both their own employees and provider services. Also, the statistical report should give the actuary a good base of data for designing a plan which will result in costs that will be lower for the employer. With the Reagan administration installed in Washington, a safe prediction at this point is that we will not see a company enter a national health care plan in this decade. One law that is due for review this year is the one regulating and funding Health Maintenance Organization (HMO). This review may mean the end of feasibility and pre-operational grants, as well as loans that were granted in the past by the federal government to set up HMOs.

HMOs in the 80's will be less regulated. The level of mandated benefits should decrease, experience rating will probably be permitted instead of community rating. In this environment, the weaker of the over 200 HMOs will disappear. On the other hand, if Congress enacts a law permitting the deduction of only the first, say, $1,000 of employer costs related to health benefits, strong HMOs may be in a good position to increase the current 5% of the population presently covered by all HMOs. Pricing in the 80's will be influenced by the economy of the 80's. The most important element of the economy that will influence our industry in its pricing practices will be inflation. As George Goodman, also known as Adam Smith, points out in his book Paper Money, "In the past decade we have developed not only inflation but expectation of inflation." Everybody expects it. The expectation of inflation by our customers will influence the marketplace, and we should prepare for the demand of the marketplace by anticipating what the inflation and the economy of the 80's will be like. A recent article in Fortune is entitled "How GE Manages Inflation". Today corporate policy at General

Electric is based on the conviction that high rates of inflation are here to stay and that they dictate certain strategies and tactics. You may or may not believe that 10% or a double digit inflation rate will be with us for the next decade, but as an actuary, you must make projections of what the future holds and be prepared to implement pricing strategies based on the events as they unfold. One of the tactics adopted by General Electric has been to share their strategies and insight with their competitors. The reason for this is that the General Electric managers feel that their competitors do not know their costs, and so they set their prices too low. In an industrial corporation, there is a tendency to undervalue capital assets, and also to undervalue inventory at the end of the year. The article went on to state that in service industry all businesses understand their costs and tend to set prices that provide a real profit. On that point I disagree because I think that even in our own industry there has been a tendency to underprice services. In fact, like banks in the 60's and 70's, insurance companies have, in recent years especially, undercharged for services. They have offered them at levels close to cost or sometimes below cost instead of charging at prices that include a more normal profit. To offset this policy, both industries have, in the past, used lower interest rates than they would have otherwise used in determining the credits on amounts left in their hands. This started to change in the late 70's. In the current decade, I think that pricing will and has to be more realistic. Our goal is to not only break even on services, but also earn a better return on the capital invested to provide these services.

As far as interest rates are concerned, forecasting an inflation rate, as I have stated, will exert the main influence in their level. In addition to high rates of interest, we can expect that they will fluctuate more widely than in the past. These rapid changes in interest rates will necessitate a shift from the practice of using portfolio or calendar year rates to credit or charge interest. These changes will be necessary if we want to maintain and increase the level of reserve that we hold. Insurers on short term reserves may have to treat these as short term funds, akin to money market funds, and determine rates accordingly. I expect that more corporations will fund retired life reserves either on their own, or as a result of accounting or legislative changes. For these reserves, the number of investment vehicles will increase, and we will see greater use of asset liability matching instead of participating in the general portfolio of an insurer.

In the 60's and 70's, in most cases an insurer had the luxury of determining expense factors on a retrospective basis. Today, even on insured cases, this is to some extent no longer the case. Customer and consultant expect the administrator of a plan to predict the level of expense charges more accurately than in the past. On the renewal date, they also expect a price that will be close to the illustrative charges given to them at the time of sale. Of course, on administrative service agreements the fee is always set prospectively, and the administrator there has to learn the discipline of carrying out the plan as detailed in the agreement. This discipline has to be impressed on everyone, but a special effort has to be made to educate the field force trained under more traditional insurance practices where accounts were settled at the end of the year. One large risk that we are starting to realize is the question of extra contractual damages. This risk is real but

very hard to assess at this point. A conversation with your legal counsel might be enough to give you the urge to check if you have contemplated this risk. If not, make sure that you do, because it will not get any smaller in the 80's.

In this decade, the key elements in pricing will be the assumptions made on the capabilities of computer systems in the design stages. More and more, the actuary and the systems people will have to price computer systems that are still in the design stages, and they will have to factor their impact on the workflow and the productivity in the claim and the administrative office.

In the past, without too much effort, the production cost of jobs done on the computer was lower than the cost of these jobs handled by clerical people. Although I would expect this to continue, or at the very least that computerization will produce a better product, it must be realized that we have reached a point where we have to better predict the inflation rate in the cost of computer personnel, in particular system analysts and programmers. Unless we get a breakthrough in programming, the present shortage of programmers and systems people and the associated impact on our costs will be with us for most of the decade. At the present time, hardware costs represent 20 to 30% of the total cost of computer services. Because of the demand for programmers, and because the price of circuits is expected to decrease, I would predict that by the end of the decade hardware may represent only 5 to 10% of computer service costs. And if this happens, it will be harder for us to limit our administrative costs. As you can see, the life of an insurance company actuary will be full of challenge in the 80's. We will have to explain our actions better to all our public: employers, clients, and employees of the client, as well as government and consumer agencies. To quote records, we need strategies for tomorrow; strategies to take advantage of new realities and to convert turbulence into opportunities.

MR. VILLA: Our next speaker is Bob Benedict from California-Western States Life. Bob spent the first half of his career with Prudential where he got a broad background in personal insurance, group pensions and group insurance. He then became the group actuary and later the chief actuary of Cal-West. More recently Bob was group actuary at Phoenix Mutual, and recently Bob returned to Cal-West as Senior Vice-President. As you can see, Bob has a very good background in both the large and small group case market, from which he can comment on the group insurance perspective.

MR. ROBERT C. BENEDICT: The purpose of my presentation is to speculate on the pricing and marketing of group insurance in the 1980's from a broad or general insurance company management viewpoint.

My presentation will proceed from a discussion of the thrust of an insurance company to an enumeration of some of the more important historical perspectives through a number of potential scenarios for the 80's and culminate in a generalized suggested approach, which will probably be no surprise to some, if not most, of you.

The insurance company philosophy is an obvious starting point for my presentation. And, with respect to that philosophy, it must be decided what products -- life or health, at a general level, or at a slightly

less general level, *Life* vs. *Medical* vs. *Dental* vs. *Long Term Disability* (LTD) -- are going to be emphasized and which are not. The company must also decide on philosophy with respect to size of case, because small cases often mean standard packages with limited benefits, whereas jumbo cases mean customized benefits and maximum flexibility. Distribution channels must be assessed: Is your company a strong career agency shop or are independent brokers its primary choice? The company's organization may be a totally integrated group operation, under the direct control of a single person, or a functional set-up with dispersed control, or something in-between.

And, of course, the company philosophy with respect to the three-legged stool of benefits, rates, and commissions must be ascertained.

Some might add service as a fourth leg, but the other three, if properly coordinated, can excuse a significant lack of service; in my opinion, one can survive for a long time with mediocre service in many markets, if benefits, rates, and commissions are competitive.

The company's marketing thrust is (and it has been for a long time) influenced by the external environment, which includes, of course, the

- Economy, where inflation affects both salaries and the trend of medical care and where unemployment (for most companies) affects LTD;

- Political/Regulatory forces at both the federal and state levels, especially in the area of mandated benefits. Also, not to neglect the force of consumerism;

- Social/Cultural changes, as reflected in developing trends with respect to marital relationships, minority issues, and age or sex discrimination;

- Industry/Competitive trends, which is just another way of looking at that 3-cornered stool; and the current

- Realities of the Marketplace, which include the enormous control of brokers, the onerous burden of mandated benefits, the multi-headed monster of inflation and the slave/master dilemma of automation.

Given that rosy picture, let me add the dimension of historical perspective which all of us have had to live through to a lesser or greater degree. I suppose I could have done a lot of research on dates and durations of these phenomena, but I prefer to merely list them and, if you are inclined, you can do the research. We have seen, for example, multiple employer trusts (MET) used and abused, both insured and not insured, often to avoid the aforementioned burden of regulation, sometimes very effectively and sometimes with the result of a "black eye" for the industry. Nevertheless, it has been an imaginatively-conceived and challenging marketing approach. Third party administrators have emerged, sometimes in concert with METs, to take a significant role in the contest for the right to administer an employee's business. They have been so effective, as a matter of fact, that some companies administer their business only through third parties! Dental has emerged (and

is still emerging) as the fastest-growing weed in the marketplace. Is the moral of the dental story to look to California for future developments?

Alternate funding devices, which for years had been looked at askance, are now an established, thriving part of the marketplace. Also, Minimum Premium Plans, cost-plus arrangements, and 60-90 day premium drags have become so popular in the large case market that their partially self-insured counterparts have caught the contagion, and now even the smallest group which has confidence in its experience can get some "bread" if it is willing to gamble on the continuation of that trend. Aggregate stop loss has become a part of the vernacular, as a necessary corollary to such arrangements.

From time to time, the group insurance industry has been bathed (most recently, last year) in an upsurge of medical expense claims which, though touted as a sudden increase in utilization, has, nevertheless, a curiously and, perhaps, predictably cyclical aura to its occurrence. And, finally of course, the historical proliferation of mandated benefits which needs no further comment.

So -- we know from whence we came, and presumably, we know the company's philosophy -- but what will the future bring? I do not know! I can, however, paint some potential scenarios. Specifically, can you imagine (or, perhaps, can you afford to ignore the possibility of):

- More self-insurance and cash flow arrangements, even on the smallest cases?
- Shorter and shorter medical expense rate guarantees (unless, of course, inflation becomes more predictable)?
- Discounts for non-smokers or other habits of good health?
- The widespread use of mini-computers or terminals in both field and home offices?
- Occasional tax forays, such as Section 79 and Retired Lives Reserve?
- More targeted marketing?
- More, but slower, development of Health Maintenance Organizations?
- More use of cost containment mechanisms?
- Continued growth of Dental, especially in the small-to-medium size case market?
- With the possible exception of Group Auto, no truly "new" products?
- Continued demands for mandated benefits, culminating in federal intervention?
- The demise of the career agency system as we know it today?
- The demise of classification of risks by age and/or sex?

- Cross-country communication by satellite, including electronic mail and teleconferencing?

- Centralized collection and dissemination of data from provider to a central data bank to carrier -- "paperless" processing?

Where do we go from here? Let me suggest an approach, which, though generalized, may bring some order to this speculation. Let me suggest that, in order to cope with what I believe will be a most challenging decade (a decade which is already more than 500 days old, so you are already late if you are just starting your planning now), you

1 - Get a clear definition of your company's philosophy, especially with respect to marketing objectives

2 - Target your markets as to products, size of case and all other important parameters

3 - Analyze your strengths and buy some expertise, if you do not already have it "in-house"

4 - Build a sophisticated data base, if you do not already have one

5 - Develop a responsive pricing capability

6 - Regularly monitor your results

7 - Be "ready". It is like that story about Bill Bradley, Rhodes Scholar, professional basketball player for the New York Knicks after all-American at Princeton and senator from New Jersey, a person of no mean credentials. Bradley was alleged to have thrown a basketball over his head without looking at the basket which swished through the net. And to have said to his interviewer that you must develop a sense of where you are. I would guess that he was not only talking basketball!

8 - Test any approach against all the potential scenarios which have a high probability of occurrence.

I would make one last comment: In the 1980's, certain things will change and certain things will not; and of those things which will change, some are predictable and some are not -- the question is to define or predict what will change and what will not and to recognize, in so far as possible, the dimensions of what is not predictable.

MR. VILLA: Our last panelist is Dick Bilisoly from the Wyatt Company in Chicago. Dick represents the other side of the spectrum: the people who buy the insurance that Claude and Bob put together and sell. Dick spent the first half of his career on the opposite side of the fence working for various insurance companies, and during that period of time he became familiar with and an expert in various parts of business with particular emphasis on group insurance. Since 1966, Dick has been associated with the Wyatt Company in Chicago where he is primarily a consultant on group insurance. So he brings broad experience to us like the other gentlemen, but a very, very different viewpoint.

MR. RICHARD S. BILISOLY: As a member of a consulting firm, I would like to discuss factors touching upon the marketing and pricing of group benefits from the standpoint of the buyer. Naturally the buyer attempts to obtain desired benefits as economically as possible. Basically, however, he is subject to most of the same forces and constraints which confront the group insurers.

Apart from the aforementioned forces and constraints, competition with other employers for workers has always been a primary inducement to the purchase of group benefits. Such competition is probably even more important to the growth of group benefits in the 80's than was the case in the two previous decades.

Fifteen years ago our group consulting activities seemed chiefly directed towards answering the employer's questions: "Am I getting a good deal from the insurer? Can the retention be lowered? Should we be putting the group insurance out for bids?" Even inquiry involving the feasibility of full or partial self-insurance is becoming passé.

Today a much greater proportion of our time is devoted to such questions as "How do my benefits stack up to those of our competitors? How do my life, disability, medical and dental plans rank percentile wise? What do I have to do to reach the 75th percentile?" Perhaps this shift in the direction of the employer's questions is not surprising when we consider that upwards of a third of additional amounts devoted to meeting payrolls are typically required to cover all fringe benefits in the typical case. This proportion has, of course, increased greatly in the 60's and 70's. According to Chamber of Commerce surveys the cost of fringes averaged about 22% of payroll in 1960, and about 37% in 1979. (These percentages include Social Security, Workers Compensation, and Unemployment Compensation.) As will be noted in a moment, there are reasons to believe that expansion in fringe benefits may slow considerably in the 80's.

It is interesting to note that surveys aimed at discerning employee preference show medical expense benefits and time-off with pay to be the two areas most appreciated (and most in need of improvement). This preference is, no doubt, a result of the likelihood of immediate use of such benefits.

Apart from competition for workers, what factors have impacted the cost and marketing of group insurance in the 1960's and 1970's? Are the same factors likely to be operative in the 1980's?

1. In the U.S. regulation of group benefits at both federal and state levels has been an influence in the past and will undoubtedly continue as such in the future. Examples: state group laws; Medicare; tax laws affecting contributions and proceeds; EEOC rules; the Age Discrimination in Employment Act (ADEA). Because of recent sentiment in the United States for reducing the role of Federal Government, agitation for some form of National Health Insurance appears for the moment to have abated. Governmental budget cutbacks may well reduce Medicaid payments, Social Security disability payments, and even payments to workers who retire early.

2. Economic factors have affected the course of group insurance in significant ways. Persistent and generally rising inflation has lead to almost continuous adjustment of group premiums and benefit limits. Employers desirous of controlling costs have greatly stimulated the design of alternate funding approaches, of various administrative techniques and of competitive delivery systems (e.g. - HMOs). One emerging trend seems to be that of requiring employees to bear a larger share of increasing insurance costs - this after many years of diminishing employee contributions.

   In the wake of high interest rates, certain group benefits requiring relatively large claim and contingency reserves (e.g., long term disability) require that much greater attention be paid to the disposition of reserves. Buyers of group insurance are more anxious than ever to gain control of such reserves. Economic statistics indicate that the rate of savings has diminished in the U.S. and that productivity indices (at least in some sectors of the economy) have declined. These factors, coupled with increasingly formidable foreign industrial competition lead some observers to wonder if the growth of group benefits has not reached a plateau. Indeed, a prominent opinion research firm has detected a significant change in outlook among workers in the last year or two. The general mood has changed from one of expansive economic optimism to the point where three-quarters of today's workers do not expect to do any better financially than did their parents.

3. During the last twenty years a pervasive and oft-noted "philosophy of entitlement" has influenced spending for benefits of all sorts, including employee group benefits. The desire for "more of everything" backed by the Labor Movement has expanded both the amount and scope of such benefits. Until rather recently it appeared that expansion would continue almost unchecked.

   As noted earlier under economic factors, however, events seem to be moving swiftly to stem new growth in fringes. Inflation, desire to control costs, cutbacks in government spending, and changing views regarding the distribution of resources are already operating to constrain expansion. So an interesting change seems to be emerging. Perhaps recognizing that there might, at least currently, be a limit to growth in group benefits, increasing inquiry is heard about the possibility of allowing individual employees to choose those benefits which suit them best.

   Although "cafeteria", or "flexible benefit" programs have been implemented in only a handful of companies so far, we see rapidly increasing interest in their feasibility. Formidable obstacles (for example, administrative costs and anti-selection problems) face the designers of these plans. But the burgeoning interest is in consonance with other findings of the opinion researchers: workers in the 80's exhibit much more tolerance for differing lifestyles than was shown only a decade ago. Working women, husbands staying home, a general blurring of traditional sex roles are becoming more common. These changing attitudes plus increasing desire on the part of workers for recognition by, and participation in, the management of business all help foster what seems to be a movement toward flexible benefit programs allowing much greater employee choice.

> A final development, one in only an incipient stage when viewed as an employee benefit, is the emergence of so-called "lifestyle programs". Employers such as Kimberly Clark and the Sentry Insurance Companies have instituted voluntary programs including physical checkups, personal physicial fitness routines, smoking cessation, weight control, and stress management for their employees. Preliminary studies tend to show that protracted efforts in these directions can confer very significant improvement in mortality and morbidity rates. Results such as those emerging from the Framingham and other studies (some reported recently in our own newsletter, The Actuary) indicate that to a significant extent our longevity and well-being lies in our own hands.

In summary, while the proportion of financial resources devoted to employee group benefits may not grow due to the force of recent trends, the imagination with which these resources are applied appears to be more lively than ever.

MR. ROBERT SUJECKI: You mentioned at one point that due to the lessening of the idea of entitlement, some employers are cutting back on their fringe benefits. I would have thought just the opposite would have occurred, that as the government cuts back on social programs, the employer might pick up some of these, and more employee benefits.

MR. BILISOLY: Well, that may be true in the future. I was just thinking that, looking at the percentage of payroll devoted to fringe benefits, there does statistically appear to have been a leveling-off in the last five years or so. To corroborate that perhaps - strengthen our belief in that - these public opinion surveys which are carried out fairly frequently do seem to really show a significant swing in overall worker opinion and public opinion on the provision of benefits. If you think back to the 60's, the employers, as providers of benefits, were lambasted continuously and more and more was demanded. But it really seems to us and to the people who carry out the surveys that there has been a swing in opinion. For instance, there is the phrase "the undeserving poor". I do not know how many of those there are, but I am sure you have heard that phrase,and it is gaining greater currency.

MR. JOSEPH N. MORAN: The caption on the subject for this discussion was group insurance marketing and not just employee benefits. I am curious about the fact that none of your panelists, Bernie, chose to address the question of potential expansion of the group insurance marketing mechanism beyond its traditional lines to new types of group, and what they foresee for the 80's in that direction. Does any of them want to comment on it?

MR. BILISOLY: Well, it has been my impression that the group insurance mechanism has been in use for quite a long time, providing for example, association group and trade and professional associations. In fact, when I was affiliated with an insurance company 15 years ago, it seemed to us that the group concept was almost always over-applied. For instance, one time I remember we got a request for proposal from a group which we later ascertained to probably be the Ku Klux Klan. We were rather happy to see that most group statutes precluded providing insurance to a group of that sort.

MR. LAMOUREUX: My comments may not be directly related to the association business, but when you asked your question, I thought you were going to ask about the trend right now for the group mechanism to be used for optional life, for instance, and dependent life. I know, in the group area, one of the things that we have seen is a lot of demand for optional life and dependent life or mass marketing, to some extent, of individual life with lower commissions. This is happening right now. But maybe you can comment on your question.

MR. MORAN: Oh, I am just trying to find out what ideas you people have. I have plenty of my own.

MR. BENEDICT: I have seen in the last 24 or 36 months as many or more requests for association quotes as I have ever seen. I see no slowing down in that marketplace. As a matter of fact, I see a little more aggressiveness among Long Term Disability (LTD) marketers for getting into that which was always the bane of LTD specialists. I think there is another market that is showing itself in various ways. It is in line with this other discussion that is going to go on, the blurring of the line between group and individual. We have recently heard requests for coverage for things like the board of directors for some of our larger cases. When you reflect a little bit upon the concept of retired lives reserves, the idea of a close retirement funding (which is a concept which has been around for years and years with group continuance funds and some large public utilities who had money they did not know what to do with, and I will not go into that any further)... that concept, has been brought up, jazzed up and remarketed as retired lives reserves. It looks like an individual product, but it is a group concept and it is relying on the tax advantages of Section 79. You talk a little bit about that, and then think a little bit about this universal life that is the current rage in the individual side (which is again low-ball term insurance with a side fund), and they are very similar products. So you are coming at it from the individual side, and you are coming at it from the group side... You are getting people interested also in interest.

MR. VILLA: I think that you will see in the 80's a continued expansion of employer supported plans of life insurance for employees and their dependents where the employee picks up the full freight on an age-related basis. We saw it come in in the early 70's when we started in the auto industry. We have just completed enrollment on the federal employees' group life insurance plan. We do not have results, although I saw preliminary figures last week that indicate they bought the dependent coverage like hotcakes, to put it mildly. The other part of the plan did as well as we expected, if not better. I cannot really say that I saw final figures to tell you how it really did. I think, with the employer sponsoring benefits of this nature, you are going to still see the association type of insurance and the credit card insurance, etcetera, all come around. But I think the payroll deduction mechanism, if the costs are age-related as they should be properly, will result in the employer taking the marketplace away from the credit cards and some of the other types of associations. I may be 100% wet, but that is my personal opinion.

MR. RICHARD J. NELSON: Considering the terrible inflation we have had in the past year and a half or so, and the makeup of our current group

contracts for medical where we give one-year rate guarantees on most of our products, does anyone foresee the possibility of going to less than one-year rate guarantees on our medical products, for example, monthly rate guarantees or instantaneous rate guarantees?

MR. BENEDICT: I think there are some companies in the marketplace right now that are doing less than annual rate guarantees. What kind of a rate guarantee do you have on your car insurance? Six months? How far away is group medical, for example, from casualty? Maybe there is a lesson there. I have nothing against shorter rate guarantees, and I think it is probably in line with one of the things that I believe in: responsive pricing. Perhaps actuaries should be recommending to management to go in this direction. They have strong bottom line orientation (maybe even a weak bottom line orientation in light of last year).

MR. JOHN A. FESSENDEN: I would like to direct this to Mr. Benedict. In your talk you commented on the three bases of rating, commissions, and benefits, and you made the comment that a company could survive for a long time with very poor service. I wonder if you were referring to any particular segment of the market, that is, with regard to size or target or benefit structure? I find the comment surprising when we think of ourselves in many respects as a service industry, particularly on the medical side where in some senses there is less direct risk compared to life insurance.

MR. BENEDICT: I do not mean to be picky, but more precisely my wording was that a company could survive with mediocre service and for a very long time if they are competitive in benefit and rates and commissions. I would never say that they could survive on very poor service. The segment of the market perhaps you are referring to there is the larger case. Especially if there is also a sophisticated broker involved, the more sophisticated policyholder will not let even mediocre service survive for long, regardless of how competitive benefits and rates are, and how long-standing a relationship they have. I do not mind making that remark, whether it is surprising or not. I do not think service is as important as benefits, rates or commissions in the marketing of the group insurance package, and I do not think it ever will be, with the possible exception of the very large case market where rates mean retentions. Benefits are determined by other people who employers try to keep up with, and commissions are sometimes non-existent.

MR. VILLA: What do you think the future is, from your viewpoint with the customers, of flexible benefits similar to the educational testing service?

MR. BILISOLY: It seems to me that when we got into the area of flexible benefits (our company is not in it that deeply, in a consulting sense), there is a great deal of interest. But it would seem to me that of every ten companies who might look at it, two might consider adopting it at the present time because of the roadblocks and the difficulty of administration. There is a high cost of administration when you look at people who are continually changing their benefits, and there does seem to be a degree of anti-selection. So for the next several years I

would see a very small percentage of employers looking at it, and an even smaller percentage actually adopting it. Nonetheless, there is lots of interest. Would you like to comment Tom?

MR. THOMAS E. WAHLROBE*: We are into flexible compensation in a fairly big way in terms of our commitment, and a lot of the clients that we are seeing do it, and actually get in and study it. There are an awful lot of people studying it because it has been heavily marketed by the consulting firms for eight to ten years. There are also two major insurance carriers, one in particular that has devoted $7 million of corporate overhead toward developing a flexible benefit system to market actively. At least it is labeled flexible benefits. When you tear it apart, it is not really that flexible; it is really a marketing surge to push the true group auto and group legal, in addition to several other packages. My question is in response to what Dick was saying. None of you addressed the competition bills which are currently before Congress and which even the most pessimistic people say may pass within this administration, probably by the end of the next Congress. The bills are not well-defined yet, but we do know that the most onerous features of all four major bills there now will require each employer to have at least three benefit programs which they offer employees from three different carriers, or in lieu of same, a flexible compensation of benefits program. So what do you all think about pricing those things and where can we go from there?

MR. VILLA: I think it is going to be very difficult because, first of all, it is going to add to the administrative costs significantly, for instance like doing a substantial revision of the plan every year. The second thing it is going to do is cost you up-front bucks because of the way coordination of benefits (COB) works with both spouses working.

I should think that the proposed purpose of these bills will be met because it is not going to change somebody's habit of utilizing services if they are still getting the same bucks; it is just going to cost the employers more money because they will be giving the differential out in another manner. In effect, it will affect the cost upward - more administration costs plus more benefits and credits, or whatever the final solution does come out. As far as the flexible benefits themselves, there is a very strong intangible that I think an employer does get; he gets alot more employee appreciation of what the benefit package is. If you talk to the average employee on the street and say, "Do you have group insurance?" "Sure we've got it." "Does it cover life insurance?" "Yes." "Does it cover disability?" "Yes." "Does it cover medical?" "Yes..." and dental you might get a yes or a no. "Does it cost the employer alot?" Well he does not know, unless he happens to utilize the medical plan, and he does not really care. I think when you have a flexible benefit program in the nature of the ones I am familiar with, the employee appreciation goes up from zero to maybe 30%. You can put different tags on it, but it does not get to 100% of the bucks being spent on behalf of the employee. How much is the improvement of employee appreciation of a plan worth? It has got to be worth something. But putting a price tag on it is as subjective as it comes.

*Mr. Wahlrobe, not a member of the Society, is affiliated with the Wyatt Company in Washington.

MR. BENEDICT: I believe you have something of an analogy now with HMOs. Where you have a dual choice situation, the employer has to properly solicit it. You can get somewhat of an analogue to what is anticipated with the procompetition bills. I probably would agree with Bernie, that somehow it would lead to increased administrative costs. Somehow it has to be more expensive to administer 25 plans than two or one. The ideal would be a good HMO and a good insured plan, and let them go at it. But I do not know if you can ever reach that ideal. I think a lot of the HMO failures are probably illustrative at that point.

MR. DANIEL L. WOLAK: I was interested in what Claude had to say about the Retired Life Reserves (RLR) in the future. One question would be: with Generally Accepted Accounting Principle (GAAP), do you feel that it will require employers in the near future to set up a balance sheet liability for the post-retirement coverage of the retirees?

MR. LAMOUREUX: I would think yes; the employer will have to recognize these liabilities on the balance sheet. In fact, at this point many self-insured employers do not recognize any liability. Not only Retired Life Reserves but also some Open & Unreported (O&U) that they do not recognize. In the near future, we will see accounting firms or the government agencies requiring them to recognize these liabilities in their balance sheet.

MR. BILISOLY: Doesn't the ending segment of Federal Accounting Standard Board (FASB) 35 address that problem somewhat? I think it says something about the desirability of prefunding post-retirement death benefit and medical expense benefits. Isn't that right?

MR. VILLA: I do not think it mandates prefunding. They are still talking about recognizing the cost on the balance sheet. In my experience, I have seen very few employers address the medical area (which is a time bomb. If you have an open-end medical plan for your retirees, you are running inflation against an interest rate. Instead of having a discount, you have a build up, and then the liability is fantastic.) We at Metropolitan do have a number of large employers who have a ton of money put away for retired life liabilities. I know some of the other major carriers have similar types of reserves. I also know of other ones that recognize the cost on their balance sheet. But in doing business you have to recognize that something is coming about, and you have to have a second set of books to see if you are making a profit after you have amortized the post-retirement costs.

MR. WOLAK: Do you feel this might affect the RLR as a growth type product?

MR. VILLA: Oh yes, I think so. The insurance carriers have been at a substantial disadvantage due to Blue Cross discounts, especially here in the Northeast - Ohio, Western Pennsylvania, New Jersey, and until a year ago, New York State. What do you think the future of the Blue Cross discount is, as we know it today?

MR. BILISOLY: We work with a lot of employers who have Blue Cross. It seems to me that in the Midwest, those discounts are not nearly as

large as they are in your area. (I have heard of 14% discounts in your area, whereas in ours you see 2% and 3% discounts.) But regarding competition between Blue Cross and the commercials, the discounts do not appear to have made any difference at all in our area. In fact, I see increasing disenchantment with Blue Cross, and they have an increasingly difficult time keeping up with the commercials in the Midwest.

MR. VILLA: Recently, a number of large insurance carriers formed a corporation to attempt to set up an electronic system to collect claim data from providers of services and transmit it, etcetera. What affect will this have on the insurance companies, third party administrators (TPA) and Blue Cross/Blue Shield along the way?

MR. LAMOUREUX: I hope most of you are familiar with this idea which involves a number of insurance carriers forming a subsidiary and collecting data from a hospital, then resubmiting this data to the insurance company. In essence, you would avoid a large part of the clerical operation in a claim office. (I do not know if TPA would be invited to participate.) Initially this was formed by a number of large insurance companies because they could see savings in their claims, they could also see improving their service. I do not know what impact this will have on the TPA, but I would expect that a number of insurance companies will want to join. The cost of joining is not cheap, especially if you want to realize the maximum savings that this corporation will give. You have to have a computer adjudicated system or something close to that, otherwise you are just getting on a tape what you would get on a piece of paper, and it may not be that useful.

MR. BENEDICT: It seems to me that it is a little more critical than Claude points out. Maybe he is in one of the companies that is on the inside track, in which case he does not have to worry about it as much as those of us who are not. Just envision yourself if this were in place, and you were in competition with a company that has this capability - that is, of paperless processing. From provider to the centralized data bank and back to that carrier, a claims processor processes on an adjudicated system, goes back to the data bank and back to the provider. The data is never touched by human hands except on the keyboard, never a piece of paper, and the provider gets the check much faster. The carrier does not have any claims files. The employee of your employer client goes into that same doctor with a piece of paper and the doctor asks, "What is this piece of paper? I have a terminal here that hooks into..." Or the hospital says, "What are you giving me this piece of paper for?" And even if they do agree to fill out the piece of paper and continue to fill it out for the next 10 or 20 years, look at the competitive disadvantage you are at by not being set up so that you can interface with that kind of centralized data bank. The time, the paper, and therefore, the money involved in not having such an interface is a critical issue of the future.

MR. MORAN: Bernie, you brought up the question of Blue Cross discount in association with President Reagan's proposals on cutting back the growth in federal outlays for Medicare and Medicaid. Is it not likely that the Medicare/Medicaid discounts will create even more of a cross-shift to the patients we insure than Blue Cross has given us?

MR. VILLA: I would hope that the negative impact of any programs that the Reagan administration puts in will affect us and Blue Cross equally so. Neither would they get a significant competitive advantage that they do not already have, nor would we get a significant competitive disadvantage, although I think it is a little early to try and guess where we are going. We saw what happened to poor Mr. Reagan when he wanted to reduce the Social Security to 55% at age 62. (I do not think that is going to fly.) Maybe in a couple of months we can take a better guess.

I have one more question for my panelists. Let's say that we are all sitting in this room 10 years from now, and we look back and look at cost containment in the 80's. What will be our great successes, and what will be our great failures in that particular area?

MR. BILISOLY: It just seems to me that increasing access to what the computer can do will make us all aware of the kinds of double/triple coverage that there are, and would aid in cost containment.

MR. BENEDICT: At one time I thought that second opinions on surgery were the greatest thing since sliced bread. From what I have read, the only way it works is if it is mandatory and that creates as many problems as it solves. On a voluntary basis, it is not very effective cost containment. I wish somebody would contradict me on that, because I always thought it would be a cost containment mechanism. I also thought precertification of hospital admissions was a neat concept, and some of these HMOs and other HMO arrangements seemed to get a little more results out of that end of things than the insurance industry generally has been able to. I agree with Dick, that the computer could help us, but I am not too optimistic about cost containment.

MR. BILISOLY: I know many HMOs have failed to work, and yet I have heard such good things about them, and because of some of the statistics coming out of the operation of the HMOs I wonder if they might not in themselves be cost containment opportunities in this coming decade. I am alluding to such statistics as those pertaining to the number of days in the hospital per 1,000 persons insured. The evidence that has come out so far seems to indicate an amazing drop in some of those statistics. For instance, 600 bed-days per 1,000 persons covered as opposed to maybe 900 or 1,000. If they did become viable, they might be the greatest way of all to effect cost control.

MR. LAMOUREUX: I do not know if the success of the 80's will be that of the insurance company or the consultant. I think the industrial employer out there will force cost containment somehow, maybe when they really get involved, we will have more success than now.

MR. VILLA: To date I think we have been selling more sizzle than steak. All the cost containment that the various people have talked about is nothing, honestly. I look at two places where I hope we will have success. First of all, when we get enough data together, we will be able to intelligently discuss with providers the patterns of care that we observe in their situation versus the average situation, and by discussing the patterns of care and the associated costs, we will convince the providers to be a little more careful about extra hospital

days and so forth. The second area with which I think we will have some success will be employee awareness. The panelists were talking before we started about the number of people on the smoking side and non-smoking side of this meeting room, and I guess we have 20% of the people on the smoking side. Two of the people were smoking in the whole meeting, so this shows that if you can educate the average person he will take better care of himself. There is hope in that area, but to quantify the results will be most difficult for us.

MR. BILISOLY: I was interested in Bob's attitude to second-opinion surgery. I have heard such differing comments on it, myself. One large insurance company maintained that very significant amounts of money could be saved by using second opinion, whereas I think the "Blues" came out recently and said it made almost no difference. Bob, in your remark you seem to indicate that the jury is in on that and that maybe it really does not help very much.

MR. BENEDICT: My essential distinction was mandatory versus voluntary. I think Spencer's Research Reports had some studies a few years ago. I think there is a very good article in there summarizing the whole thing. It probably needs to be updated; it was written back in 1975 or thereabouts. But basically it concluded that if you have a mandatory second surgical in your program, especially for the really elective operations, that it can produce savings. Regarding voluntary, they decided it was not worth it, but the mandatory runs afoul of telling the doctors how to practice medicine. There is some kind of legal problem there, I think, so you lose.