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

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1. The 1960's and 1970's
   a. Major influences
   b. Benefit changes
   c. Alternate funding approaches

2. The 1980's Environment
   a. Regulatory (including National Health Insurance)
   b. Economic and growth potential
   c. Competition (including Health Maintenance Organizations)
   d. Technology

3. The 1980's
   a. Evolving role of employee benefits
   b. Products
   c. Pricing considerations
   d. Marketing approaches

MR. JOHN P. COOKSON: Our first speaker from the panel is Ed O'Neil, Group Actuary of New England Mutual Life. Ed will review the 1960's and 1970's and will try to set the stage for where we are and where we might be going.

MR. EDWARD W. O'NEIL: What were the key regulatory and economic factors operating from 1960 through 1974 which affected the course of Group Insurance benefits and pricing in the 1970's? Are those factors still operating and what effect will they have on the 1980's? Also, are there any new factors which will affect Group Insurance in the 1980's?

REGULATION AND LEGISLATION

1. The federal income tax law for life insurance companies, dated 1959, actually precedes the 1960's. It has little impact in the 1960's. It emerged in the early 1970's as a force to be avoided. Recognition of reserves as "Life Reserves" and the Menge adjustment prompted movement of Group business to either a separate corporation or reinsurance arrangements. Selling through a new corporation meant new surplus goals and therefore different profit charges. Using reinsurance arrangements left companies with an open tax question: how to reflect the advantage of these arrangements, if they could be easily unravelled by an IRS auditor.

   State premium taxes were a minor consideration, about two to two and one-half percent of premium.

2. State and federal regulators seemed relatively quiet from 1960 to 1970 and let Group Insurance and most other business alone. Certain state regulators had always made life interesting, but most of their attention was directed toward individual and not Group policies. In the late 1960's and early 1970's regulation inflation became uncontrollable. State and federal bureaucracy worked overtime on regulation and legislation controlling all business, not just group insurance. As an indication of legislative activity during the 1970's, the federal register in 1970 contained about 20,000 pages; by the end of 1979 it contained about 80,000 pages. The reason for this increase was not the size of print, nor was it the use of simplified language to describe complicated ideas. Anyone reading ERISA can attest to that. It was simply more federal control in all aspects of business. Reacting to protests of the 1960's, government tried to become socially responsible. The federal government set up the Environmental Protection Agency in 1970, the Occupation Safety and Health Administration in 1971, and the Consumer Product Safety Commission in 1972. Between 1970 and 1977 the number of major federal social regulatory agencies rose from 12 to 17 and the total budget for those programs rose fivefold. The cost estimates of administering and complying with this new social direction is estimated at $100 billion in 1979. We paid our share as did most industries. ERISA, passed in 1974, is an excellent example for our own industry. Certainly, there was some abuse in pension funding and investments which needed correcting. However, the cost benefit of such widely applied legislation should be challenged. One question is if anyone in Washington has ever read a Form 5500 or whether plan participants have truly benefited from a summary plan description in readable language.

3. Medicare and Medicaid was enacted in 1965 and resulted in a near immediate expansion of hospital and medical services. Federal expenditures were initially $42 billion and were nearly doubled by 1970. More legislation was introduced to control this segment of the federal budget. (Early in the 1970's federal legislation was the only thing inflating faster than medical care.) Some of the legislation of the period, like the 1971 economic stabilization program, the 1974 Health Planning and Resources Development

Act, and with it the certificate of need programs, tried to reduce the spiraling medical cost and, in general, group insurers benefited. Other legislation, like the 1972 Medicare and Medicaid amendments, aimed at reducing the federal committment to those programs, but only shifted cost to Group Insurers. The 1972 amendment set reimbursements limits for those covered by Medicare and Medicaid.

4. The threat of a National Health System was always there through the 1960's and 1970's. To some extent Medicare and Medicaid were first steps. One wonders if we would be covered by a national health system if the Medicare and Medicaid system had been a financial success. In any case, the threat of a National Health System may have had some impact on benefits offered. It certainly had a direct impact on group expenditures. Company management were hesitant to make the substantial computer investments in a product soon to be federally administered. The view was that only a few insurance carriers would have a role in a National Health System. The companies that did not computerize faced the mid-1970's with growing expenses.

ECONOMY

1. I am sure everyone here is familiar with the history and impact of inflation. In 1960 the CPI was about 1 percent. Inflation over the 1960-1964 averaged 1½ percent a year; from 1965-1969 it averaged 3½ percent; 1970-1974 averaged 6 percent; 1975-1979 averaged 7 percent. We have now come full circle and the 1980's averaged about the same as 1960 - about 1 percent. The 1980's rate, however, was per month. Perhaps we have only telescoped a year's activity into a month. Growth in the money supply may have begun this spiral, but lack of control of the money supply seemed to keep correction out of the control of the Federal Reserve until lately. Not until October of 1979 did the Federal Reserve adopt a new strategy to control the stock of money. They targeted bank reserves but not bank rates. The consequence for housing and auto sales was unacceptable. They loosened the reins and inflation took off again.

   Again, the Federal Reserve restricted the money supply. This time they seem to be more serious.

2. In the latter part of the 1960's the post war "baby boom" hit the work force. Although not materially impacting either Group benefits or pricing, the political and social activism of this group did much to produce the regulatory environment and the philosophy of entitlement which were a pervasive force in the early 1970's.

3. Savings, productivity and capital formation in the United States ran a reverse course to inflation. The higher the inflation rate, the worse the savings and capital formation rate and productivity rate. Because of a decline in saving and capital formation, the growth in productivity rates have trended down over 1960-1974. We as a nation seem more interested in consumption

than savings. The inflation spiral and our tax code may be the reason. The consumption versus savings attitude is reflected in the move of Individual Permanent insurance toward individual Term products. From 1960-1974 the growth in productivity, although declining, averaged about 2½ percent.

4. Investment income from 1960-1974 grew. Group Departments in the early part of this time period paid little interest to the 4½ percent to 5 percent received on assets. Assets of Group business as a percent of the companies' portfolios was small and the after-tax impact on price was small. Near the end of the period, however, things were changing. New money rates were increasing, investment returns of insurance companies were beginning to feel the impact of the Menge adjustment, and policy loans were causing a cash crunch which was supported by the Group departments. For example, our new money rates were less than 5 percent up to 1967; by 1969 they were over 7 percent, the next year over 8 percent and by 1974 they were almost 9 percent. Policy loans in 1960 were about 8 percent of the Ordinary Life Reserves. By 1974 policy loans were 31 percent of Ordinary Life Reserves.

BENEFITS

How did these factors affect the benefits and other services we offered? Regulation expanded coverage by defining eligibility, termination of coverage and disability definitions. During the late 1960's and early 1970's there was a shifting of cost. What had been covered by public assistance programs was now being added to employer provided plans. From 1965 to 1973 productivity was increasing about 2 percent a year. The standard of living was still moving up. Paying these marginal costs was accepted and probably lost in the cost of other benefit expansion which was also taking place. In order to attract and retain employees and because the tax break favored it, employee benefit plans added dental, vision, prescription drugs, and even legal insurance. Shifting cost, addition of benefits, plus inflation led to larger and larger employee benefit budgets. No one wanted to cut the level of benefits, only the cost. Self-insurance not only eliminated premium taxes and risk charges, it also sheltered investment income and improved employer cash flow. For those plans not large enough for self-insurance but which needed more control on cash flow, there were minimum, retro, and deferred premium arrangements.

PRICE

Pricing during the period was one of coping with the changing environment and expanding rate manuals.

Regulators were adding coverage faster than most Group departments could comply. Many companies established departments whose only responsibility was to read and respond to legislation. Rate manuals included annual,

then quarterly, then monthly factors to keep pace with the escalating cost of medical insurance. Trying to solve the problem, the federal government imposed price controls. This, however, only added more regulation and only delayed the inflation spiral. Since inflation during the period was substantial, annual review of pricing was potentially dangerous. In addition to inflation adjustment, some companies updated rate manuals semi-annually, some prepared to rate inflating benefits, others cut back rate guarantee offerings. As if benefit changes and inflation were not enough, the investment income, Federal Income Tax Law, and "Menge" adjustment spawned new problems. Companies entered into reinsurance arrangements for tax purposes and multi-corporate environment, all of which led to revaluation of surplus and profit needs of group lines. Unfortunately, most of the work was old before completed, as inflation would hit a new high or cash flow from policy loans would far exceed expectations.

Now let us look at the last five years, 1975-1980, and guess at what their impact will be on the 1980's.

REGULATION

1. The federal tax situation has worsened. Not only did inflation push investment return near their peaks with respect to the Menge adjustment, but it also reduced further life and health tax advantages for employees.

   -- It is a lot easier to go over $50,000 of Life Insurance than it used to be.

   -- The $150 medical premium exemption is also easier to exceed.

   -- Employer provided disability income exemption is changed. Now with a $20,200 cap on the $5,200 deduction, the tax advantage of employer provided disability income will shrink.

2. In addition to federal tax, the states began asking for more than the 2-2½ percent of premium. We should expect state income tax to become more important in the 1980's as states scramble for additional revenue. The state's need for additional revenue may in part be due to the loss of premium tax on self-insured plans, but it is probably more a general need for increased state revenue. The states are also suffering from runaway costs and at the same time facing taxpayers' rebellions. California's Proposition 13 and Massachusetts' Proposition 2½ are examples. Because of Proposition 2½, Boston will lay off 4,000-5,000 employees next year. That is about 40 percent of their total payroll.

3. The federal budget is similarly being cut back forcing further cuts in Medicare and Medicaid. The Health Care Financing Administration has, since 1975, been increasing the application of

Section 223 of the 1972 amendments to Medicare and Medicaid. Those amendments set reimbursement for hospitals and saved those programs about $250 million in 1980. States have similarly cut health coverage financing by failing to increase eligibility standards for Medicaid to keep pace with inflation. Over the last 5 years, states have cut the number of Medicaid recipients by 3 million, from 25 million in 1975 to 22 million in 1980. States are also experimenting with reimbursement on a "prudent buyer" concept. This limits the choice of Medicaid recipients to only those institutions which agree to established prices.

4. Benefit regulation from 1975 to 1980 at the state level continued to increase. Each state would promulgate their own definition of complication of pregnancy or mental and nervous disorders or alcoholism as a disability. Non-uniformity of state benefit regulation plagued the industry. From 1960 to 1980 the number of new pieces of state legislation affecting our industry grew from 60,000 to 250,000.

   Whether a help or a hindrance, the federal government did decide that maternity will be treated as any other disability and set age 70 as the new limit for age discrimination. Both of these consumed enormous amounts of time in compliance.

5. Regulators attempted to decide whether sex was a legitimate determinant to price. No final decision has yet been reached.

ECONOMY

1. From 1975 to 1980 the CPI increased every year. The lowest increase was about 5 percent and the highest was about 14 percent. According to DATA RESOURCES, INC., February Report, the forecasted CPI is 11½ percent for 1981, 10.2 percent for 1982, and 9½ percent for 1983. Inflation will be with us for some time and we should acclimate ourselves.

2. From 1975 to the 1980's the post-war "baby boom" began reaching the saving versus consuming years. Instead of experiencing all of the cost of starting careers, getting married, beginning a family, they should have experienced some disposable income. Inflation and taxes may have eliminated saving as a wise choice. Society mores also changed. People were more egocentric, family ties were less important. One-parent families became commonplace. There were more women and more highly paid women in the work force.

3. Investment income followed the tracks of inflation. The prime rate hit an outstanding 21½ percent. During this period it was prudent to borrow from credit cards, instead of short term loans. Individual insurance experienced huge outflows of cash values in policy loans.

BENEFITS AND PRICING IN THE 1980's

1. The definition of what constitutes "employee benefits" will continue to expand. Competitive pressure as well as internal pressure will produce this expansion. Competitive pressure will come from other life insurers, casualty companies, third party administrators, HMO's, brokerage houses, etc. Internal pressure will come from our Individual departments as they prepare for the 1980's. As an individual switches from savings to term products, more and more of the expense load will have to be absorbed by Group lines. Companies will want to add group auto, homeowners, college tuition benefits, or brokerage services, if the tax law favors investment, payroll services for employers, etc. It seems to me we are headed toward the sale of employee services rather than traditional insurances. Self-insurance, volatility in claims results, and medical costs will push Group departments in that direction.

2. I expect a medical cost squeeze in the 1980's, and a collision between the philosophy of entitlement and the ability to pay. Our society believes medical care is a right, not a privilege. In the 1980's someone will have to pay for that right. Both federal and state governments are experiencing increased operating cost and outright tax rebellion. It seems the government will continue to shift medical costs to employer plans. Some of that cost will inevitably find its way to third party payers. Insurers can only pass it on to employers. The Blues have a superior mechanism in place to handle substantial growth in hospitals' "bad debt" accounts and will not feel the squeeze as soon. At some point, however, employers will have to bear this cost. The employer, faced with low productivity and stiff foreign competition, will shift more of the cost to employees. The employees, faced with double digit inflation and taxes (federal, state, FICA, city, excise, sales), will look to the government for relief.

3. Definitions of coverage will still be decided by regulation and by legal cases. Regulators will decide a definition of death, disability and relationship. Regulators will also determine what, if any, are legitimate determinants of price, age, sex, occupation, etc.

Because of more benefits, inflation and the government's need for revenue, aggregate Group premiums will outpace inflation. Some of the reasons I see are:

a. Medicare and Medicaid will continue to cut reimbursements. The focus of this problem will be in large urban hospitals.

b. Cafeteria plans will increase aggregate cost because of selection. More and more Group plans will offer individual benefit selection.

c. A more volatile business environment will require greater surplus and profit goals. This may lead to a few large companies being able to offer all employee benefit services and some specialty companies.

4. Rate manuals will continue to expand to account for:

   a. New benefits such as auto, legal, cafeteria plans, unbundled services (in claims payment, actuarial ...).

   b. More specific female rating, if allowed.

   c. State regulated benefit definitions.

Looking at all of these, it shows me an increasing pace of group insurance and leads me to one conclusion. All phases of our operation should be modularized. We need to be able to remove and replace elements of our entire operations quickly to respond to the changes going to be forced on us.

MR. COOKSON: Our second speaker from the panel is Bob Dobson, Financial Vice-President of Blue Cross and Blue Shield of Alabama. He will focus his discussion primarily on the economic aspects of where we have been and where we are going.

MR. ROBERT H. DOBSON: My presentation will be primarily concerned with economics and the group insurance business. To cover this subject, I must of necessity spend some time discussing how we got to where we are - so I will discuss the 1960's and 1970's. Since economics starts with individuals, I will speak largely from the viewpoint of the general public - or, if you will, the beneficiary of group insurance benefits.

Two points before I begin. First, I graduated from college with a bachelor of science degree in economics. A bachelor's degree hardly represents a credential, however and, even if it did, I have not, by any means, been a practicing economist. Therefore, I speak to you as an actuary about what economics means to actuaries. Secondly, virtually all of my background in group insurance involves medical expense coverages. Though some of my remarks may have general applicability, they are intended to apply primarily to medical expense coverages.

I said that I could not be considered an economist - maybe I should add that I would not want to be. Face it, economists have a bad name. I could fill the rest of my time telling economist jokes, but I personally believe in being kind to our maligned minorities. How did economists get such a bad name? In my opinion the bad name was derived from the attempt to predict a single future and from attempts to use the tool, economics as both a cause and an effect.

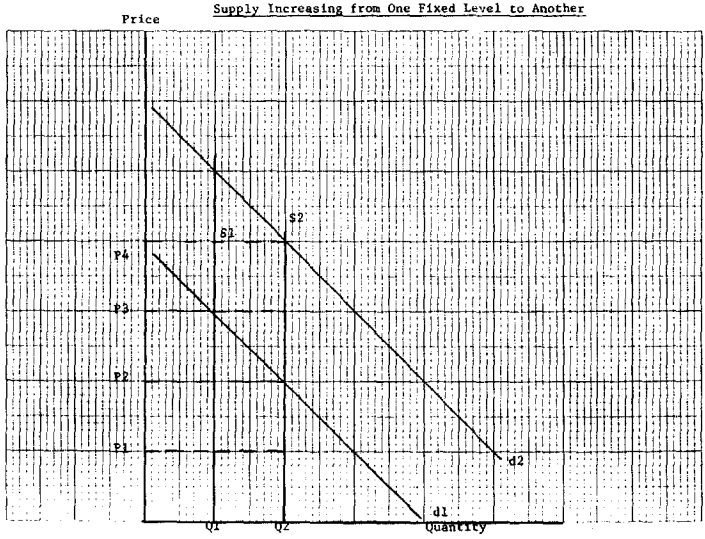
But do not get me wrong - I believe economics can be a valuable tool. That is why I chose to discuss the subject today. However, I do not believe any discipline can be used to predict the future and I do not believe that any tool can eliminate sound judgment.

So why should an actuary want to use economics and what does it all have to do with marketing and pricing group insurance in the 1980's? Successful marketing requires accurate pricing and the use of economics can help us to be accurate in our pricing assumptions. To effectively use economics we must first understand the basic laws of supply and demand as they relate

to medical care coverage. Secondly, we must take advantage of the existence of economic cycles.

We are all familiar with the basic supply and demand graph shown in Exhibit I. The vertical axis is price, the horizontal is quantity. On this graph I have fixed supply, S1. Where the demand line d1 crosses the supply line, it sets the price and the quantity. Total revenue equals price times quantity. Using the big squares as units of one, we have revenue of three times one, or three, and revenue per supplier of three divided by one, or three.

Exhibit I
Supply Increasing from One Fixed Level to Another



But now we build more hospitals - the Hill Burton Act - and we train more doctors. We still have fixed supply at a higher level, say S2. Theoretically, what happens? Lower price, higher quantity. More total revenue, two times two, but less revenue per provider, four divided by two.

Well, supply did increase drastically over the 1960's and 1970's. The number of physicians is projected to continue to increase over the 1980's. But prices have not gone down. Proof once again that economics does work? Not exactly. All this results from increased demand, by shifting the demand line to d2.

The price is now up to four, the quantity still at two. This makes total revenue eight. Remember it was three at the first level of supply and demand and four at the second level of supply. Now it is eight. Revenue per provider which was three, then two, is now four. More providers, but higher prices and more revenue per provider, all because demand increased.

I have heard it said that there is no limit on the demand for health care services. We are all familiar with the factors that increased demand in the 1960's and 1970's, but I would like to recap them briefly:

1. The fringe benefit tax advantage made benefits a favored collective bargaining issue.

2. The Great Society, Medicare, and Medicaid caused a national belief that medical care was a right - ranking, it seems, above even food and shelter.

3. Medical technology exploded - we can keep people alive under incredibly adverse circumstances.

Of course, there really is some limit - perhaps the level at which our entire gross national product is spent on health care. As actuaries involved in the marketing and pricing of group insurance, we should be prepared to anticipate the basic effects of supply and demand. We should be sensitive to public opinion as well as aware of the advent of technological improvements and increases in the number of providers.

In addition to the basic supply and demand aspects of medical care, the general level of economic activity and, of course, inflation, have a great impact on the group insurance business because of the effect on the utilization and cost of medical care services.

The economic indicators that I will refer to today are, first, the annual percentage change in real gross national product (GNP), and second, the annual percentage change in the all-items consumer price index (CPI). This is not to imply that these are the only meaningful indicators or even the best. These indicators are widely used, however, and they are in my opinion, a lot better than nothing.

Of course, the absolute values of the GNP and CPI are not meaningful. The change is useful, but even more important is the trend in the rate of change.

Let us look at Exhibit II showing a graph of the annual percentage change in real GNP since 1948.

I suppose at this point I am obligated to give some credit to our moderator and his firm, my former firm. These graphs and graphs of other important indicators are part of a copyrighted package they prepare and distribute monthly.

The amazing thing that stands out from this graph is that the line goes up and down regularly. Yes, there are economic cycles.

And, generally, utilization of medical care services is higher at the bottom of the economic cycle than at the top.

As an aside for group insurers, cash flow is usually strongest at or near the top - the worst time to invest - and weakest or negative at the bottom - the worst time to liquidate.

We should take advantage of these simple facts:

EXHIBIT II

GROSS NATIONAL PRODUCT (GNP) IN 1972 DOLLARS

ANNUAL % CHANGE

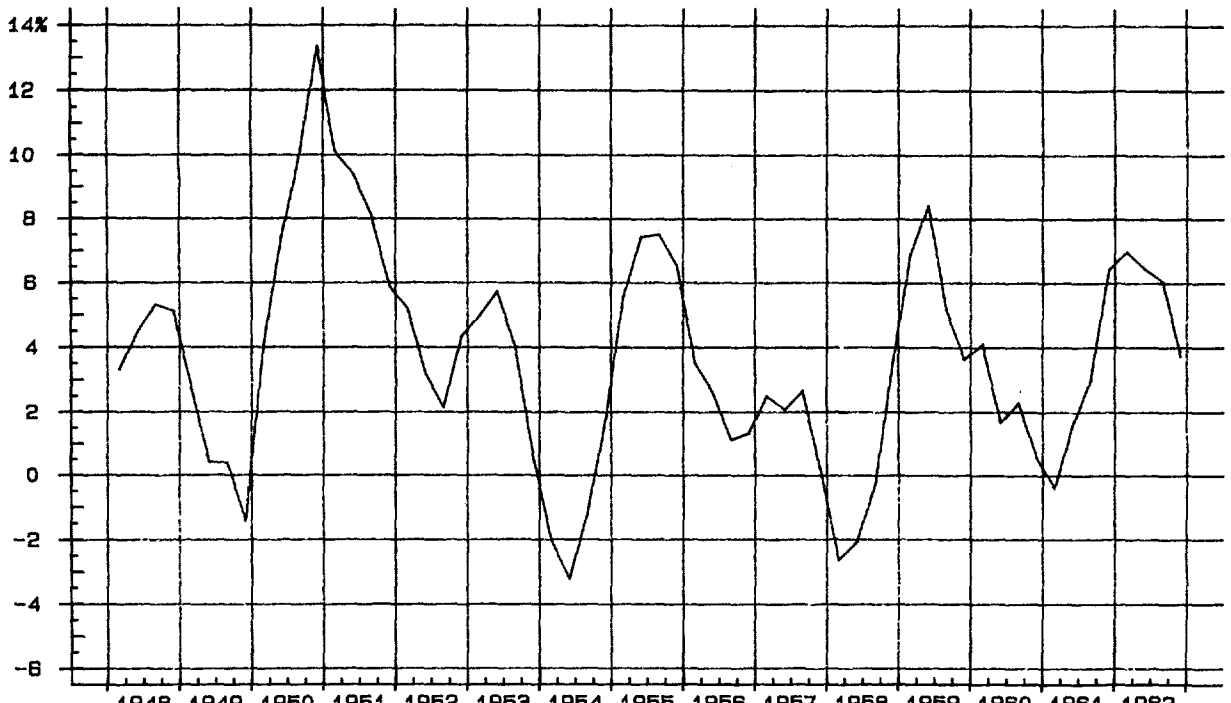


EXHIBIT II (CONTINUED)

GROSS NATIONAL PRODUCT (GNP) IN 1972 DOLLARS

ANNUAL % CHANGE

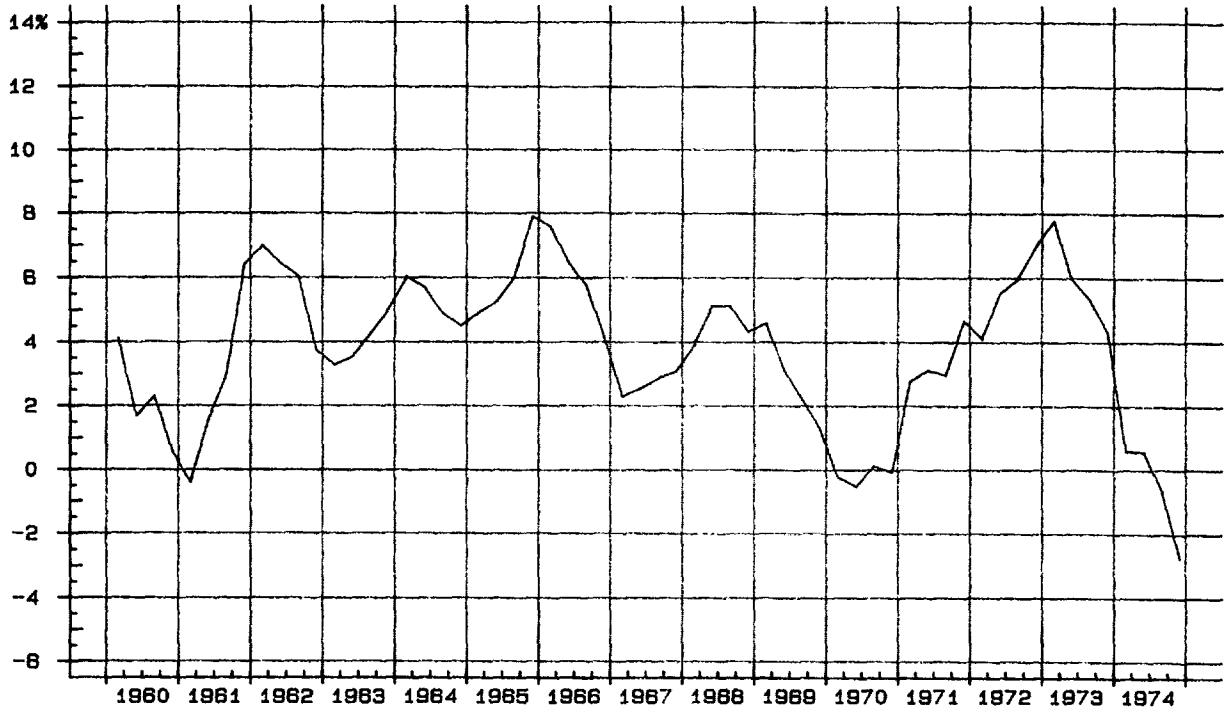
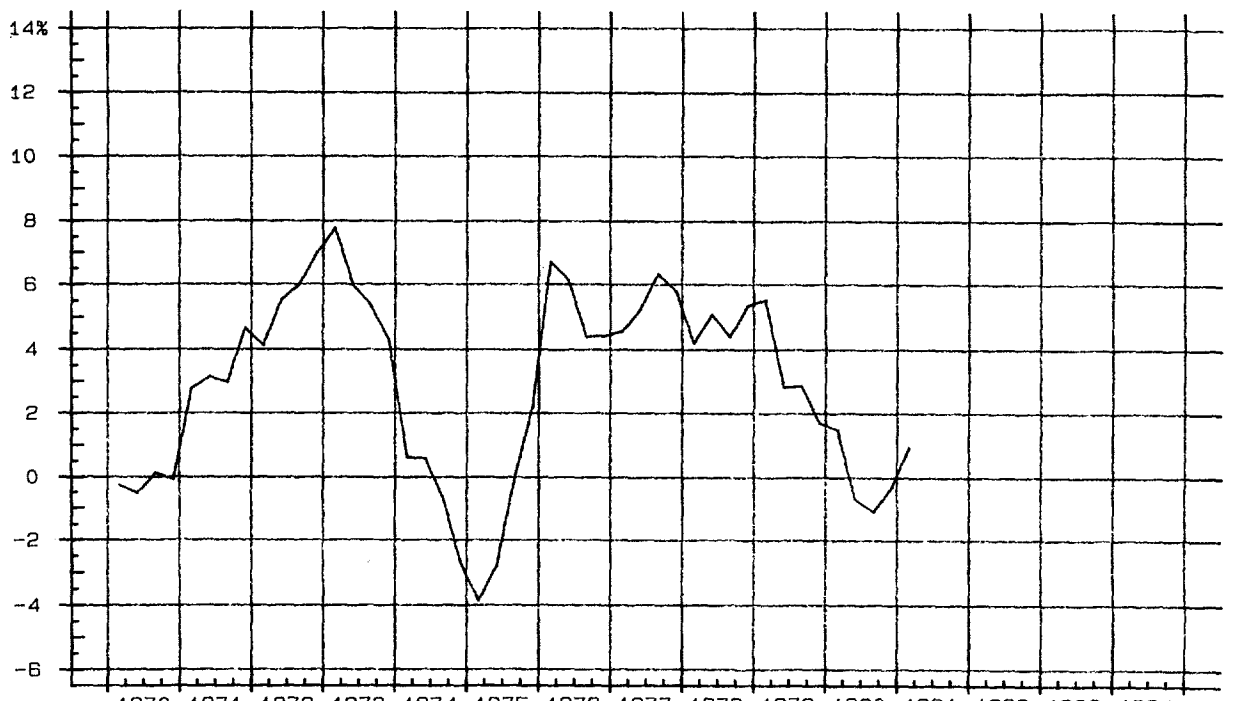


EXHIBIT II (CONTINUED)

GROSS NATIONAL PRODUCT (GNP) IN 1972 DOLLARS

ANNUAL % CHANGE



1. Economic cycles do exist.

2. The distance from peak to trough and trough to peak varies, but within limits.

3. The absolute values of the peaks and troughs vary, but again, within limits.

Exhibit III shows the graph of the annual percent change in the CPI now. Several observations can be made:

1. Prior to 1958, increases and decreases in CPI were closely correlated to increases and decreases in GNP. Many people will tell you this is still how it works.

2. There was no CPI cycle from 1958 through about 1965. Look at the absolute level, too - between 1 and 2 percent inflation, in our lifetimes.

3. Since 1965, we have had both cycle and trend. That is, the cycle exists, but each trough is higher than the previous trough and each peak is higher than the previous peak.

4. Finally, the relationship to the GNP cycle has completely reversed itself. CPI peaks now correlate with GNP troughs, and vice versa. Can this be a result of unemployment insurance and other transfer payments, or the inelasticity of our standard of living?

Whatever the cause, actuaries involved in pricing group insurance products which are sensitive to inflation need to recognize these developments and take advantage of them. Be cautious, though, the CPI cycle has not been stable. Continuous monitoring is essential.

How can we use the information we see here. We use a trend factor in rating to anticipate the future. Typically, the trend factor is determined from historical experience. Historical experience should not be the only factor, however. If we can relate our own companies' experience levels to economic cycles, we can anticipate changes in the rate of change.

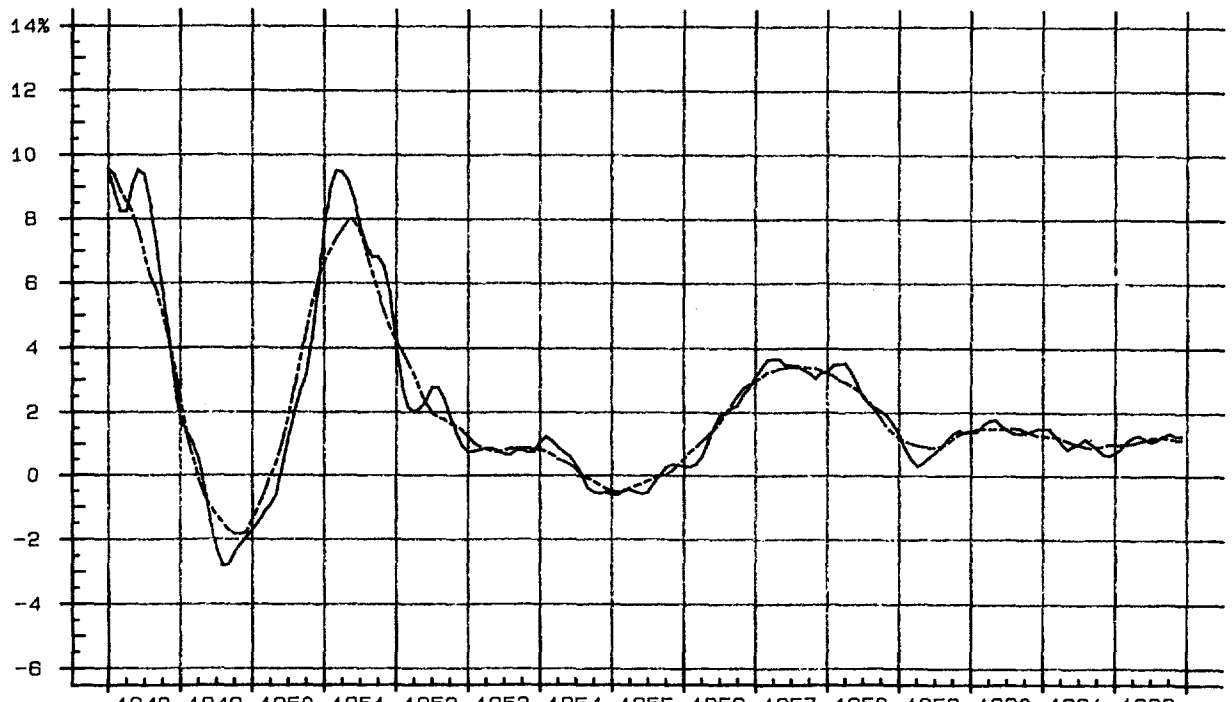
For example, if we had a group whose experience followed this graph exactly, we would look at 1978 experience compared to 1977 and see a 9% trend, 1979 over 1978 would be about 13½%. Because of unpaid claims, we would not really know the 1980 results, but from what we saw emerging in the first two quarters, we might project 15% or so. To trend to 1981, I submit that most actuaries would use at least 15%, many might use a regression analysis on the 9%, 13½%, and 15%, and end up trending close to 20%.

Recognizing in the cycle, however, somewhere between 11% and 12% seems safe - it could go lower. Of course, this involves a risk - but isn't that the business we are in?

EXHIBIT III

CONSUMER PRICE INDEX (CPI) - ALL ITEMS

———ANNUAL % CHANGE OF 3-MONTH MOVING AVERAGE
– – – –ANNUAL % CHANGE OF 12-MONTH MOVING AVERAGE



CONSUMER PRICE INDEX (CPI) - ALL ITEMS

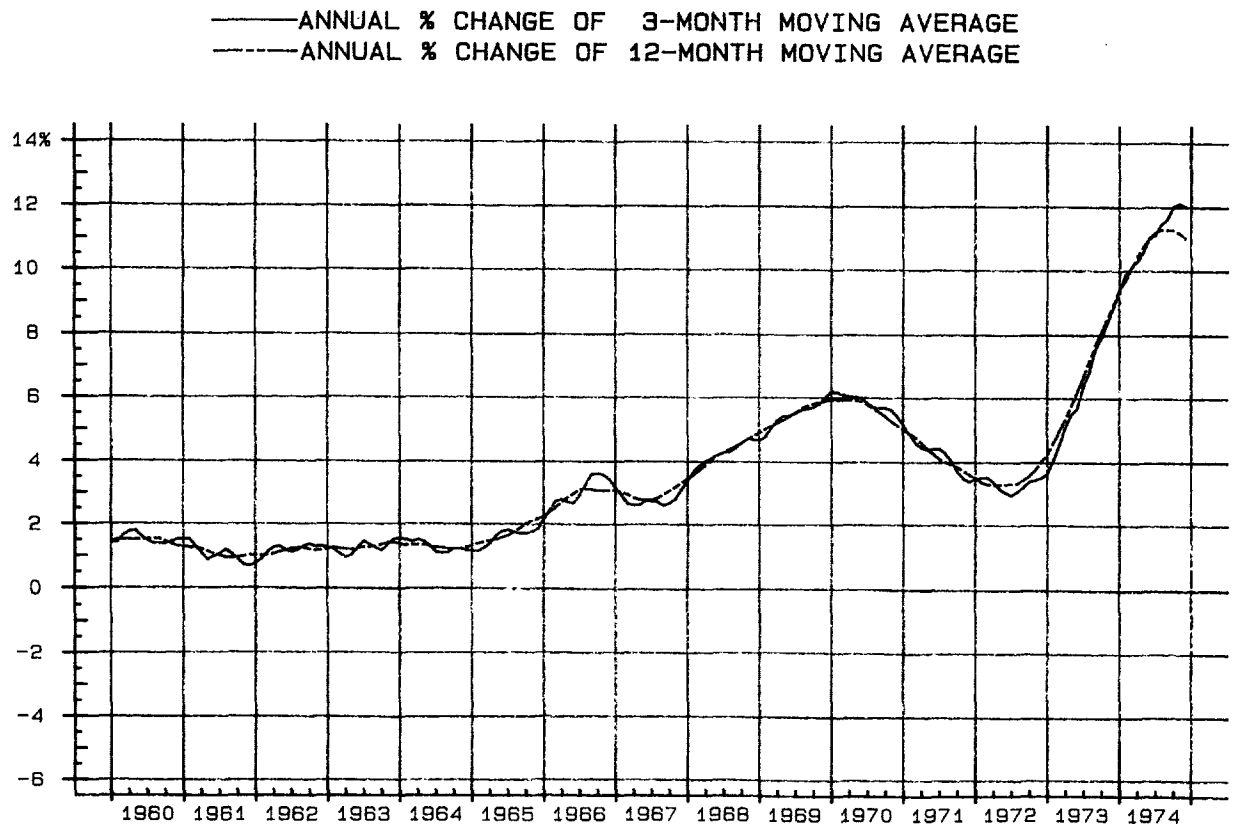
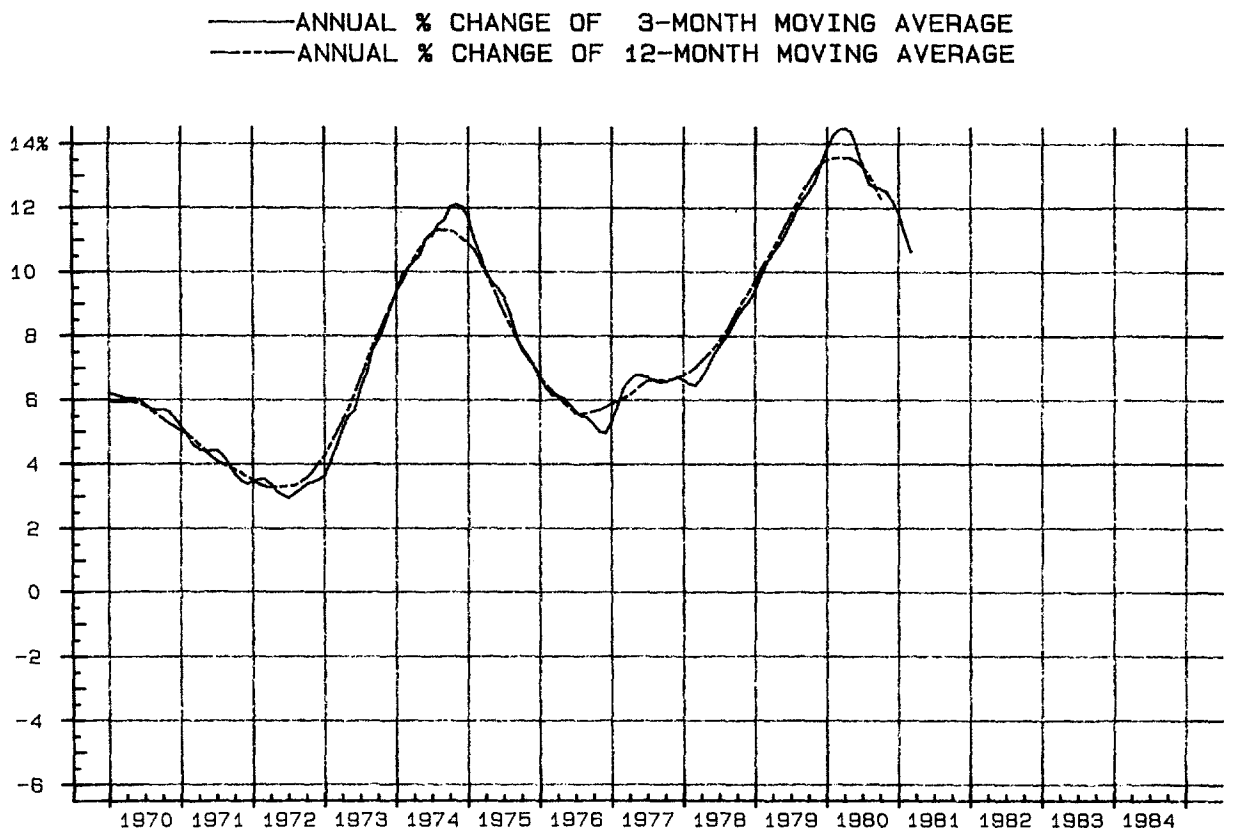


EXHIBIT III (CONTINUED)

CONSUMER PRICE INDEX (CPI) - ALL ITEMS



Recognizing cycles when the trend is turning the other way will not make us popular with our marketing people, but remember what I said earlier about accurate pricing being our goal. If we explain what we are doing, I believe our marketing will be more effective if our pricing is more accurate in the long run.

What does all of this mean for the 1980's? The group insurance business has reached a mature market status. If our income statements were adjusted for inflation, most of us would see little, if any, growth. For a particular carrier to grow, gain must be made against another carrier or through new benefits. Either way, the actuary's job is made more difficult. Pricing must be accurate and risks must be taken.

To succeed in the 1980's we need to take advantage of as many different bodies of knowledge as we can - not just economics, but management theory, market analysis, risk theory - anything at all that can be used to generate a competitive advantage. We must be ready to experiment - to be leaders instead of followers. Let us not follow the example of the auto industry because the Japanese will not step in to take over the group insurance business - the government will.

MR. COOKSON: Thank you Bob. Many of my clients would agree with you that successful marketing does depend on accurate pricing as long as it is accurate on the low side. Our final panelist, Alan Thaler, President of Alan M. Thaler and Associates, Inc., will comment on several areas including technology, products, marketing and pricing.

MR. ALAN M. THALER: Our topic this afternoon is a broad one and I shall try to stimulate the discussion that will follow the comments of the panelists with a few brief remarks on some, but not all, of the suggested subtopics. As a member of a consulting firm providing services to a number of insurance companies, I have gained some insights into the motivating factors that have been influencing trends in group insurance in recent years. Much of what is changing can be traced to inflation, high interest rates and increasing regulation at both state and federal levels.

Regulation

Perhaps the subject of regulation is a good place to begin. Certainly the conservative attitudes that were so forcefully expressed in the last national election may help to stem the tide of regulation at the federal level, but I am pessimistic about the future of regulation at the state level. I see such regulation intensifying and becoming more of a factor in the growing cost of administration and the reluctance of employers to adopt insured plans. It is highly probable that large employers as a result of state regulation will continue to move in the direction of self-insured plans and seek protection from such regulation under the federal pre-emption provision of ERISA. This increasing regulation at the state level will more severely impact individual medical and disability insurance than group, and thus further encourage the application of group insurance arrangements as a mechanism for at least partial avoidance of such regulation.

We are hopeful that there will be some abatement of new federal regulation such as was enacted in 1979 with respect to pregnancy benefits. That law, which was intended as an anti-discrimination measure, in effect has imposed an inequitable hardship on employers who are being forced to pay benefits to women already pregnant when first employed.

We see evidence that insurance companies that were backing away from the group medical expense business, because of a continuing threat of an imminent national health insurance plan, perceive national health as a more remote event and are now moving more aggressively back into this business. This is especially true with respect to those insurers who for many years have hesitated to enter the small employer group market. In part this change in attitude is due to the fact that the small employer does not have available the alternative of self-insurance as does the large employer. But also an increasing number of insurance companies now recognize small group business as an important entry into the marketplace for individual insurance and annuity business that they cannot continue to ignore.

Product Design and Marketing

One important reason for the growth of group insurance in the small employer market is that the rapidly increasing cost of health care has made individual insurance paid for with after-tax dollars unaffordable to most people. The tax incentives which permit the payment for these plans with pre-tax dollars has encouraged the formation of small corporations and the growth of group insurance plans.

There is no question that group medical and group dental plans will continue to be modified to some extent during the 1980's, but we see the increasing cost of these products as an inhibitor towards any big strides in the further broadening of benefits or the expansion of coverage into presently uncovered areas. We see these same cost considerations as a retardant to the growth of HMO plans.

Because of inflation and high interest rates, we see increasing emphasis on products which involve tax shelters, whether it be for the funding of retirement benefits for life, medical expense or other purposes. We see interweaving of what has been traditionally group pension benefits with group insurance benefits and the group pension concept being extended to include coverage which in the 1960's and 1970's was not thought of in terms of a pension plan. All of this is coming about because of the pressure on businesses of all sizes to shelter income from taxes at the federal and state level to the extent that it is possible to do so -- and this is not an unwelcome movement. In fact it is very much in line with the Reagan Administration's stated goals to promote more savings in the private sector.

In the last year or so, we have seen new products in what has traditionally been the marketplace for individual insurance that are reaching out to improve their attractiveness through reduced costs. To some extent this has been achieved through the availability of higher interest earnings, but in some situations the attractiveness has also been attained at the expense of the agent through reduced commissions. Some of the new product designs which separate the savings elements in insurance from the

term portion tend to increase the awareness of the public to high front-ending of expenses. The ability to defend rationally high front-end expense loads even on the assumption of a long term undertaking becomes more difficult as interest rates increase. I fail to see how these policy designs will do anything but proliferate, and this in turn implies fundamental changes in marketing systems and in the way that agents are compensated.

While direct marketing approaches through the use of newspaper, radio and television will continue to have some growing impact on the total marketplace, business placed by agents will still dominate. However, the technique of using sponsored situations that arise through associations and employers will grow in importance. As a part of this marketing environment, there is likely to be an increased application of group policies and accompanying group techniques to what have historically been individual policy situations. For example, voluntary payroll deduction plans which have never achieved their full potential will increase both in popularity and innovativeness through the 1980's as an effective lower cost method of marketing and packaging. Plans which include techniques for tax sheltering investment income and which embody portability will be among the attractions in this new kind of marketing environment.

Technology

One factor pertinent to product design and marketing that has become very evident in recent years is the increasing importance of computer technology. In the case of most products, group as well as individual, computer prepared proposals are now routine and computer applications are of tremendous importance in the administration of new products that are becoming available. In order to meet competitive needs, insurers are finding that they must have products which are responsive to changing interest rates, which can handle flexible premiums, evaluate experience, adjudicate claims and so forth. This technology is changing rapidly. What was considered a modern system in the 1960's became obsolete in the 1970's, and most of what was developed in the 1970's now needs upgrading for application in the 1980's. To stay abreast of this technology, an insurer cannot afford to develop systems that are intended only for use by a single company. Strides are being made towards the sharing of software systems so as to reduce developmental costs and facilitate upgrading as new technological advances are made. These changes in technology are going to play an increasingly important role in the sophisticated third party administrator area, both with respect to the application of those services to the self-insurer and for the insurer. Insurance companies will need to think of themselves as having two separate roles -- administrator and insurer -- and be prepared to play either or both roles as the situation demands. The large employer who turned to self-insurance in the 1970's but who did not have the systems needed to control emerging claim costs and forecast future costs is likely to find it more economical to purchase outside services. Insurance companies will increasingly find themselves competing with well qualified experienced third party administrators for that business.

Pricing

I would like to conclude these comments with a few thoughts concerning trends in pricing. Pricing will become a more critical matter, and

insurers and self-insurers will be reaching to achieve improvements in each element of the pricing structure. In the area of underwriting, as it applies both to mortality and morbidity, we will see a greater refinement in selection techniques. As we see further advances in medicine and improved understanding of the effects of nutrition and habits, there will be a trend to reflect these known factors in the pricing structure just as we saw the smoking versus non-smoking consideration become important in the 1970's. Another advance in analysis, perhaps primarily in morbidity results but to some extent also in mortality, will result from the important strides that are being made in computer speed and storage capacity that will permit analysis of experience to a much greater extent than has been possible in the past. For example, in the 1970's we saw important strides in the pricing of medical expense made from broad geographical categories to extensive breakdowns by zip code. More of these kinds of refinements aimed at understanding the basic factors influencing claim results will be emerging. Again, the large insurer or the self-insurer using specialized software for these purposes will tend to emerge in the forefront.

It is likely that interest rates will remain high and that this will continue to focus attention on investment results and investment methods which tend to avoid unnecessary taxes at the federal and state levels. This will place a good deal of emphasis on product design to achieve these pricing objectives. Finally, with respect to expenses, advances in processing by computerized methods will tend to favorably affect all aspects of administration and the insurer, self-insurer or administrator that does not keep abreast will not survive. The only trend counter to this will be in the cost of claim administration where higher administrative costs will be tolerated but only to the extent that they can be justified on a cost/benefit basis.

All of this is likely to lead to an increasing amount of disclosure of the total pricing structure by insurance companies and the long established practice of defining net retention under a group contract to be the net of expenses, interest, taxes and risk charge will disappear, at least on all but small groups. Even in the small group area, there will be an upward pressure on loss ratios.

All in all, the 1980's promise to be an exciting period that will see basic changes in both the structure and the marketing of insurance evolving with group insurance playing a pivotal role.

MR. COOKSON: Thank you, Alan. We would like to entertain questions and comments from the floor. This is an important subject and many of you must have something to say, so let us hear you say it. I would ask if you have a lengthy question or comment, please speak at the microphone. In any event, please stand and identify yourself and your company, and to whom you wish to address your question.

MR. RICHARD BILISOLY: I have a generalized question addressed to Mr. Dobson, Mr. O'Neil and Mr. Thaler. It seemed to me that Messrs. O'Neil and Thaler foresee a continuance or expansion of group insurance in the 1980's whereas Mr. Dobson perceives a status quo situation. Maybe that is not what was meant. Is there a reconciliation of those views?

MR. DOBSON: I guess you are referring to my comment where I mention that we are in a mature market situation. What I meant is that there are no additional groups out there and I guess Alan's comment was that more people will be trying to form groups because increased state regulation will lead to less individual insurance. Certainly, with all the competition from third party administrators, HMO's, and other alternate delivery systems, I believe that any growth that an individual carrier has, does have to be at somebody else's expense, or through increased benefits. We referred a couple of times to the tax advantages and possible changes in the tax laws that could effect the expansion of group benefits; I turn that back to you, John, for comment there.

MR. COOKSON: I am not too sure what I can say about that. There has been much talk in Washington in the last couple of years concerning a limit on deductibility to the employees of the medical expense premiums. For example, putting a cap on the amount that the employer's contribution that would be non-taxable to the employee, and this would be intended to stimulate some competition among different plans. There are also some proposed changes to the HMO laws that could possibly lead to more competition as well if, for example, the change of laws allows experience rating by the qualified HMO's. Some of the other panelists may feel that the change in administration in Washington may tend to lessen the pressure for federal laws in this area and more or less trying to reduce the amount of regulation rather than trying to increase any additional regulation.

MR. THALER: We have tried to keep our ear to the ground a little bit since the Reagan people came in a month or so ago. For example, there has been pending a new regulation under Section 79; we have seen no evidence of that going forward and we have talked with people that have reason to talk with the IRS quite often on this type of matter. I just feel very strongly that the administration is going to try to curb this kind of disencouragement of private industry effort. On the subject of HMO's, I had meant to make at least a brief reference to that. I do think HMO's are going to have an increasingly difficult time in the 1980's because of increasing inflation and because of the fact that they already cost more than the typical major medical plan that insurance companies now market. The group benefits are going to increase in importance, but the expansion into new areas of benefits is not going to be the reason for it. There will be a tendency to curb costs by discouraging movement into home health care, vision care and so on, that might have been a strong movement had it not been for the high rate of inflation.

MR. O'NEIL: I can agree with Bob that we are in a mature market and there are no new groups out there that are going to significantly affect the way we do business in the 1980's. I see the expansion coming in new products also, and again it is going to be new products at the expense of other insurance companies; perhaps casualty insurance companies as we approach group, or perhaps the savings bank life insurance as we start to mass merchandise our life products through financial institutions. It is going to be a competitive situation with expansion at the cost of other institutions.

MR. COOKSON: I would add one comment to that. Alan's comment about the HMO's is well taken. Many of the HMO's are having financial problems. Mainly that has to deal with the expertise of their management and how they got into the business. Although there are many successful HMO's

around, I would say that in my experience they have been experiencing lower trends than the commercial insurance market with respect to health insurance, particularly in 1980. I have some experience with a very large HMO which just did not see the increase in utilization that many of the group insurers did. The ones that have the controls, i.e., are able to control their providers and the inpatient admission, have to maintain a lower overall increase in cost. However, that is not true of some of the less stable HMO's. A couple of areas might provide additional expansion of business, and certainly the dental area which continues to grow at fairly substantial rates. The early 1980's will still provide this, in spite of inflation and additional markets. One area that I do not know how many insurers are into or even able to get into, is stop loss insurance, particularly in the self-insured market which is becoming more and more prevalent. Do we have some other comments?

MR. DONALD M. PETERSON: I know this is really not on the agenda, which says marketing and pricing of group insurance in the 1980's. But if you could hang in on just one of the 1980's, 1981, we have something very interesting going on right now. Half the group writers have had the reddest year they have seen in just about ten years, which we really have not talked about. Ed mentioned there is no new market really. We are just trading groups among ourselves. But it seems as though the Prudential is out looking for a 45% rate increase on group A, and New England will look at it and say well maybe we can write it at 137% of last year's rate. What do the panelists think the 1981 activities will have on the next couple of years. For Mr. Dobson, are we really at a trough or are we still heading down to GNP of minus 5% and a CPI of plus 27% before they both reverse their course and we can stop worrying about utilization. As we look at our claims in the home office, we are shocked by the number of over $100,000 claims on an individual. A few years ago, say 15 or 20 years ago, group medical insurance was like haircut insurance. You could price it pretty accurately. Now there is a real live risk element in it. The variation is far greater than we have seen in the past, and yet now all the large groups want to self-insure. Everything seems to be going in the wrong direction. From an economic standpoint or from a pricing standpoint, I would like to have any of the panelists' response.

MR. THALER: I will be glad to respond to the extent that I can, Don. I do not like to quote companies here, but you did mention a couple. Part of the problem with these current very large increases that you are seeing in 1981, is the fact that we had this COWPS business in 1978, 1979 and 1980. The insurance companies were placed under a lid, which was an artificial lid, and they were trying to cooperate. For awhile there was even some belief on the part of the insurers and the hospitals that this was in fact happening, and this program of President Carter's was going to have some effect. If you check back on the rate increases that were imposed by these same companies in 1979 and 1980, you will find that they were inadequate and what we are now witnessing is just a catching up of the rate increases that were not put into effect in those years. Now things are going up at a steeper clip at the moment. But if we had continued with the normal rerating process, which was artificially interrupted by the intervention of the federal government, we would be having a more normal rate increase this year. And I think no more than a 20% increase would be in effect and possibly less. I do not know if that answers your question, but that is the way I see it and

believe it to be the case. I do not think things have gone particularly haywire. As far as these high claims are concerned, I suppose that must be anticipated with the kind of coverage we are writing. This whole business of high claims and unexpected trends just reinforces the point I was trying to make that we need better management information systems and quicker reaction times. Many companies that are in this business of medical expense insurance still have a very slow reaction time. They do not perceive what is happening until eight or ten months after it has happened and then it takes another eight or ten months to react. If you do not have a system that is automated and can react more quickly, you really cannot afford to be in the business.

MR. DOBSON: I would like to add something to that, Al. I completely agree with what you said and I think that is consistent with my comments. I certainly would not pin my career right now on whether or not we are at the economic trough, but we have got to be following our own experience as close as we can and see when we hit that point and see when it turns. Getting that information is really crucial.

MR. O'NEIL: There is historical precedence here. If you take a look back at the CPI in 1973 and 1974, just after Nixon imposed wage and price controls, there was also a slow down and a few good looking years. Suddenly they came off and inflation just started to climb again, and we also had bad years at that time. There will be a more volatile business future and it is going to lead us all toward heavier surplus demands. I think some of us will be able to afford it, some of us will not. That will be a critical decision in whether we are going to be in employee insurance or in employee benefit services. As far as selling it for 137%, I would say that we have been very conservative. We are not looking at another good year. Our first quarter results were a little bit worse than last year.

MR. COOKSON: You mentioned the large number of over $100,000 claims, which we have seen also. Are you suggesting a retrenchment, or perhaps a roll back and/or limitation, either annual or lifetime?

MR. PETERSON: Not necessarily, but maybe a different outlook in the way we go about rating group insurance. In past years we would look at a group and define it as a good group or a bad group based on the last couple of years claims, and set next year's rates relying heavily upon the past couple of years of claims. There is more volatility now and there is a large claim charge we have to include in all of our rating concepts. You cannot go to full prospective experience rating at as small a level as perhaps we were able to a few years ago. Yet as I mentioned, it seems as though the marketplace is looking for ASO with some extremely high stop losses. Those two phenomenons seem to be at odds with one another. I do not know how to correct it or change it if I am right.

MR. COOKSON: Well, I certainly think there needs to be some kind of rethinking or reconsiderations of the essentially blank check given in health insurance now. We have seen claims or hear of claims approaching one-half million dollars or more in a single year. That is a lot of money to be paying for one individual in a group. Even for the largest groups, going back to Bob Dobson's supply and demand curves, that kind of blank check creates its own demand. Certainly there is some need to consider or reconsider the products that we do have available.

MR. O'Neil: I would like to suggest the scary possibility that these may be the insurance markets of the future. That is the kind of business we are in. We are risk takers. The other kinds of products that we have been servicing now for a number of years, are better served elsewhere. There are better tax breaks elsewhere and lower cost in self-insurance. We may be left with that portion of the marketplace.

MR. THEODORE W. ZILLMER: I have an economic question for Bob Dobson. I agree with you if you look at the last twenty years or so of the cycles and the CPI and gross national products; the highs and lows have been higher and deeper in the past with each cycle. I am wondering how long you think this will continue and where this all will end. The expansion seems to be greater each time around and it will have to stop somewhere.

MR. DOBSON: I am sure you remember I started out by saying that I thought economists did too much predicting. I really do not want to make a prediction. There are certainly many outside influences and governmental activities that affect that, and that is why I think we need to keep monitoring the cycles and watch them. I certainly do not know when it will stop. Who can possibly predict when it would?

MR. THALER: I might just say that I have a son who is an economist. Every time I ask him what is going to happen next year, he says that it is not my field of economics.

MR. LAURENCE R. WEISSBROT: Two comments. First, sort of an answer to the question of why are we seeing the very high inflation in our increases and we seem to be behind the eight ball in a terrible pool of red ink that we have got. And yet if you look at the CPI, and if you look at the measures, it does not seem to indicate that this should be the case. One thing that we have noticed is that hospitals are separating out various components of their costs in at least one area. The hospital room and board rate appeared to stay the same between one HIAA report and the next, but the nursing services were separated out as a separate expense item. They are doing that with many of the services. Radiology has become a separate department or separate business outside of the hospital. That was in order to get CAT scanners for a hospital when federal regulation said you cannot. But if nursing services are no longer part of the normal room and board, what comes next. We can say great. Our hospital charges stay the same and we price our hospital insurance according to the level of hospital charges. You have all of these other things that we are not measuring or that are not being measured somewhere else. It may be a trend of this type that is obscuring some of the increase and causing us to get behind in our pricing. There was a statement made before that you felt the government regulations will slow down. There is a bill that is going through now, the procompetitive bill, of which Senator Durenberger is one of the sponsors. The bill would call for at least three group insurance benefit plans to be offered by any employer with one hundred employees or more. And they must all be offered by a different carrier. That is going to have a tremendous impact on the administrative costs, both for the employer and for the insurance company that might administer this for small employers. While I agree that national health insurance has a much smaller probability of passing, this bill will probably pass in the next year or so because it was originally introduced by Orin Hatch and he is right up there in the Reagan administration.

MR. COOKSON: Any response here?

MR. THALER: Well, I would like to say something with respect to the first part of your question. That is that the behavior of the room and board charges is a terribly poor indicator of what is happening to the cost of medical expense coverage as a whole in any particular geographical area. If you try to correlate the experience of a medical expense plan by geographical area with room and board, you will not find much in the way of correlation. This is because hospital charges for room and board is a political matter. It is unpopular in many places to raise room and board charges, so they raise something else. Unless you understand the whole interplay of what is going on with the doctors and the room and board charges and the radiology and other kinds of expenses, and the environment in which you are selling the coverage, because the individual underwriters who place the business is a factor in this too, you do not have a whole picture. Now as far as this bill that you mentioned, I do not have an informed opinion on this subject except that it does seem to be counter to the stated purposes of the administration and the administration's record is too new to judge something that has been going on in the past.

MR. COOKSON: One interesting thing that I found out recently, is that there is a computer software firm that has a package that they market to hospitals. This is essentially a linear programming package that takes all of their cost data and all of their revenue data and frequencies for each department in the hospital and compares their Blue Cross reimbursement contract and Medicare and Medicaid contracts and their third party reimbursement rates, and essentially is an attempt to set their pricing structure to maximize their net revenue. So far they have five hospitals that have bought the product because the individual tells me that the controllers are not sophisticated enough to understand it. But if that ever catches on, you will see much more of this happening.

MR. JOSEPH T. FLYNN: The one thing that I do not think that you have really addressed is that we are talking about marketing. We are going to have a number of companies in most corporations in the United States next year questioning the rate increases that they are going to be getting, especially in the health line and possibly in the disability line. We have not talked at all about what we are going to be selling them or what we are going to do as an industry to help them contain some of their costs by restructuring the tax benefits we have, by repackaging our benefits, perhaps going into cafeteria-type plans. You have not addressed one of the hot markets today which is retired life reserves that are being used in the group line, and the future of that. And I would kind of like to get some feeling from the panelists as to what type of products they perceive for the 1980's and how we are going to market these so that we can keep the business and not have it all go self-insured.

MR. THALER: I thought I had addressed the retired life reserves problem briefly. This is a product for the 1980's because it provides a tax free benefit if it is properly structured, and employers and employees are anxious for those kinds of benefits. Especially the smaller employers that can identify the benefits directly with his own future rewards. And I see that as a benefit that applies not only to life insurance, where it has been marketed to some extent in the past, but also with respect to the funding of medical expense insurance. Many people have

not focused on the fact that medical expense benefits for retired lives is a needed product. The reason that it is needed is that Medicare is not doing the job. I do not know what percentage of the bill Medicare is picking up now, but it is probably under 40% of the total medical expense bill. As someone remarked, Medicaid is being cut back, so even if a person is poor, there is less reliance on that. Therefore, I think we will see more funding for retired people.

MR. O'NEIL: We had a good year last year in disability income (DI). The economy did go down, but it went down in an area of the economy in automobile and housing and probably many of us do not have much disability income in this area. It is blue collar versus white collar. As for the first quarter of this year, our disability income product is again performing well. We are probably not going to be looking for increases in 1982 either. As for the medical, how we are going to help them cope is probably in a traditional way. We are also offering an outpatient product at no cost. Our thought is that this is a market experiment and this outpatient utilization should offset any in-hospital costs without increasing the total costs.

MR. DOBSON: I would like to say something about the cost containment issue. Being with a Blue Cross and Blue Shield Plan, I hear an awful lot about this and we are supposed to be experts in it, but we find that although the groups talk about cost containment, and want you to tell them what you are going to do about it, they are not willing to pay for it. They look at the retention and want to see the lowest possible percentage. I only get the impression that the people talking are really doing the least. They are just cranking the claims through which can be more cost effective, so I would like to see a positive answer to that. I would like to be able to say that our cost containment efforts are successful in keeping groups from going to self-insurance through third party administrators, but I do not see it right now.

MR. GREGORY W. PARKER: I would like to get back to what we were discussing on how everyone got surprised with the results of 1980 after the reasonably good years of 1978 and 1979. I would agree with Alan that there was a degree of catching up in 1980 by refusing the marketing pressure. To realize what was happening, I have seen not only from our own experience, but from some other studies, that indicated utilization in 1978 and 1979 actually took a down turn. I should say the rate of utilization was declining from what it had been in previous years. Then, all of a sudden in 1980 it just turned around and went for a whopping increase. I would like to ask Bob Dobson if there is any way that utilization can somehow be correlated to the economic trend - the economic cycle. It certainly looks like if you look at the way utilization has been bouncing around, it is not terribly measurable.

MR. DOBSON: That is something that we have studied and we do not have any real good data at our particular Plan. But it is certainly widely understood in the group insurance business that the economic cycle affects it, and that at a down turn in the economy the utilization goes up. I think that certainly had an impact on 1980's experience. We do have the same experience that you were talking about, decreases in 1978 and 1979 and then a jump back up in 1980. I am sure that one of the factors among many was the state of the economy during the year. There are a lot of other things that go on that can affect it too.

MR. COOKSON: I think more people are beginning to subscribe to the theory that the stress from a bad economy does carry over and impact an individual's health and then manifests itself in the medical experience sector.

MR. BILISOLY: Working for a consulting firm, we are called upon many times to look at the feasibility of self-insurance, in particular self-insurance of medical expense benefits. Getting back to what Don Peterson and what you, Mr. Cookson, said, it is disquieting to see these large claims emerging and they do indeed seem to be emerging with an incidence that is bouncing around too. It is disquieting for many reasons, one of which is that it is very difficult to plot the variance, say the standard deviation, of it. We are called upon many times to try to determine probability that losses will exceed say 120% of expected, or some such attachment, I guess you call it in the insurance business. While it does not seem to be too terribly difficult using theoretical models to look at the distribution of losses on life insurance and long term disability insurance, there is a great deal of variance there. The use of theoretical means to try and look at the variance on medical expense cases seems almost futile. In other words, if you compute the theoretical variance of such a claim distribution, it seems that you should triple the variance in order to account for what really does happen. Is there, in short, a way of looking at the problem empirically when having a huge group of cases which have been insured for a number of years, a better way of looking at the variance that might occur?

MR. COOKSON: Are you talking about aggregate experience?

MR. BILISOLY: Yes, I am talking about aggregate claim experience for a large group or even a medium size group.

MR. COOKSON: Certainly that is true if you are talking about using convolution techniques, a convolution type of approach to risk theory. It is because there are many factors that miss. The convolution basically is a distribution of individual claims within a year, but it misses the fact that you are dealing with groups composed of individuals from the population. You have people coming in and out of the group, different geographic areas involved, different economic situations, and different parts of the country. Our experience has certainly been that a straight convolution approach significantly understates the expected variation and loss ratios. We have studied significant volumes of year to year experience on groups tracking from one year to the next and accumulating over periods of time, and that certainly is true. We have found some mathematical curves though, that do very well represent that experience. Basically what we refer to as the difference, say the net difference between the convolution risk distribution and the actual observed experience risk distributions, is the uncertainty distribution. It really represents in some ways the underwriting aspects of the particular carrier involved.

MR. O'NEIL: My general impression, both for disability income and medical, is that you would have to make some estimate of the economic factor and that may probably wind up to be the controlling factor after you have finished all of your convolutions.

MR. KEVIN P. CLARKSON: I have a question for Alan Thaler on retired life reserves (RLR). On market research that I have come across, it seems to indicate that the market for our RLR seems to be restricted to cash rich corporations, such as professional corporations who essentially are in a position with extra money that they need to throw into something to avoid paying the tax man. It also seems that with many companies going into RLR, the amount of cases per year issued do not seem that high. Do you expect that this will influence an individual company's decision to go into RLR for medical expenses?

MR. THALER: My feeling is that there is going to be a much more positive reception to RLR for medical expense than there has been for life insurance because it has always been true that people relate more to the need for medical expense coverage than they do for life. It is something that is more nearly bought than sold. Also the cost of funding this, although this group might not recognize this fact immediately, is more manageable. I am not talking about a benefit that is guaranteed in the future. It should be recognized as fact that an employer, whatever portion he funds, funds it tax free for the employee. The employee is going to be interested in that kind of a benefit. The employer does not have to say I am going to pay all of an employee's medical expense coverage when he retires. He can say I will more or less provide a certain number of dollars per year. It can be an increasing annuity graded up at 15% a year and I will contribute that many dollars in the future after he retires to his medical expense coverage and he can pay the balance. So, when we talk of this coverage, we are not talking about a guarantee, we are talking about an important assist to a retired employee in funding a much needed benefit that very few plans now provide. This need is more readily recognized by the smaller employer, the professional employer, the small businessman, than it is by the large corporation which is more inclined to look at the needs of the whole organization. I might also point out with respect to this that Section 79 has no part in this with respect to smaller plans. You can have evidence of insurability so it is a much easier plan to put together and to market.

MR. DALE F. ETHINGTON: Basically, I just have a few comments to make. One is I agree with Don Peterson that on smaller cases it seems to me the market is definitely pushing us into more experience rating based on case experience, while on the other hand it is becoming more and more obvious that they are not that credible. That is only going to change over time as carriers lose money on these smaller cases. But I do not think that is going to happen until we are forced to recognize that. With regard to what you can do with benefit cutbacks to control the cost, there is really very little that can be done. If you take away benefits, typically the best way is to raise the deductibles to a very high limit to discourage employees from abusing the plan on small charges, you are really eliminating a substantial tax benefit from the employees that they currently get. With regard to high claims, the incidence is definitely going up. That primarily is a social phenomenon as to what people believe they are entitled to in terms of their medical care and the way technology has found ways of using the money that is available through the carriers. If I look at some of these large claims, in my own mind I have difficulty justifiying the spending of that kind of money and manpower for some of these claims and yet it is society that is dictating our approach to this, not the insurance companies.

I really do not see much way out of it, until that is reflected through our society and through the government.

MR. COOKSON: I wonder how much society realizes what is actually being spent on some of these large claims.

MR. THALER: On this there have been several references here on giving more and more credibility to small group plans. It seems to me a number of companies for quite a few years have been pooling their experience on medical expense claims above a certain amount. It is possible that the size level at which that is done should be raised, because of the increasing importance of those kinds of claims, and that the pool has to be looked at as a separate group, separately rated and a price charged against all of the groups in that pool. I imagine there are a number of companies here that have been doing that already, but to the extent that they are not, it seems to me that is in the nature of a practical answer and a way of watching what is happening to that particular segment of the market.

MR. ETHINGTON: I would like to make one comment on that item. I agree with what you are saying, and it turns out that the charges are becoming quite substantial these days. My own experience has been, and this is not really backed by scientific study, that there are a number of cases where large claims come in year after year on certain cases, which seems to be more of a result of hiring practices of the employer rather than being some statistical sampling of employees from the population. So, you get groups that have no large claims year after year and you have had them for ten years. You will have other groups where there are two and maybe three large claims every year, far more than you would expect from a statistical basis. So you have a difficulty in trying to present your case to that employer that has no large claims year after year as your charges for these things are going up.

MR. THALER: Perhaps this comes into the area that I was referring to in the need for refining our underwriting techniques in the 1980's. I really think this is part of the answer and maybe we are moving closer to what the casualty companies do in terms of rating automobile risks on bad drivers, and so forth.

MR. FLYNN: First of all, we quickly touched on retired lives reserves and we have not brought up the fact that there is a potential problem with that at this point - a tax problem upon a person reaching age 65. I believe the government is looking at it and saying that if you issue somebody a paid-up policy at age 65, that is now considered a gift and taxes are payable at that point in time. That is one of the big drawbacks to that type of coverage, so we are not sure that that particular avenue is available to us. If that is not, it looks like companies will fund the benefits as they pay them when people retire. If that happens, I just wonder what the accountants will do with companies that have this potential liability that is not currently being funded. That is an area that is possibly going to change in the coming years. We should be thinking, as an industry, about how we are going to handle that.

Another thing that I wonder about is we have not talked too much about cafeteria type plans; with potential packages here we can wean people away from some of the coverages. It appears now that possibly one of

the reasons why our claims might be going up is we no longer have coinsurance on many of our policies because we have got husbands and wives working and they both now have coverage and because of our integration limits there is no real risk to them. There is no reason for them to get off claim. Are we doing anything or thinking about anything in our benefit structures for ways of structuring our policies to see if we can make it more restrictive for them to continue on benefits? Again, I am getting back to the benefit thing. Is there anything that we are doing along that line that is going to be a new direction for our industry for the 1980's?

MR. THALER: I would like to refute to some extent the statement you made on this tax question under RLR. There are some routes that are quite unsafe and some companies have chosen to go those routes. We think there are some safe routes that you can pursue for the funding of these benefits that will avoid the tax liability at retirement. I do not think this is the forum to go into for the solutions to that problem. Perhaps, Ed, you would like to address his second question.

MR. O'NEIL: No. We are not doing anything at all in coinsurance or benefit rearrangements to correct for two members of the same family working.

MR. PETERSON: On that second subject, not specifically with the two members of the family, but with the idea of coinsurance and deductible, during the HIAA Group Officers' Round Table this past December, a number of the large writers, some of the New England companies especially, have recognized that an alternative in lieu of going out with these large rate increases is to offer the client an opportunity to implement some cost saving restrictions in the area of coinsurance and deductible in order to mitigate to some extent the rate increase. I believe actually one of the carriers did it with their home office plan and gave the employees an option. The employees could pay for the rate increase to maintain their coverage, or keep the old rate with changes in the coinsurance and the deductible. We have got some plans out there with $25 deductible that have not been changed in 25 years. When you couple that with some of the other things, they have really added to the escalation in costs. But the HIAA is making a big push along these lines with the member companies. One other comment on Alan's favorite subject, retired lives health insurance, our company has written one or two on some executive employees in an industry which we are familiar with. It is a nice program. Along the same lines as far as the RLR is concerned, we have already a beautifully well-built marketplace. Every single employer who provides retiree group life insurance is a hot prospect to prefund it at the expense of Uncle Sam. Let us be honest about that. If they are paying one year term costs for the retired life insurance product and they are paying taxes on profits, there is an ideal opportunity to kill two birds with one stone. That should be an interesting market in the 1980's, especially from a group standpoint where the commissions are much lower than doing it with individual products. This might in turn get you into trouble with the Internal Revenue Service with the presentation of a paid-up policy at 65.

MR. COOKSON: I think we ought to break right here. I would like you to spend the last three available minutes filling out your evaluation program and dropping it in the back. I would like to thank our panelists, and also the participants from the audience. Thank you very much.