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SMALL GROUP

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Operating a successful small group program of two or more lives:

1. The role of the agent and sales management
2. Techniques for monitoring financial results
3. Protective choices in benefit design
4. The use of individual underwriting including substandard ratings
5. Rate guarantees and frequency of rate adjustments
6. Trends in coverage

MR. HOWARD J. BOLNICK: Small group insurance has been a source of continued controversy. Over the past year, in particular, we have seen visible problems such as significant losses from some very large, well regarded insurers, and the movement of large amounts of business from one carrier to another due to outsized rate increases, benefit reductions and cancellations. It would seem to even the well-informed observer that small group is a dismal swamp which quickly swallows up all who venture into it. The insurers that have been working in this morass, though, have been developing and searching out ways of doing business on a profitable basis, and I believe, and I think our panelists today believe, that there are opportunities out there for small group to be turned into the marketing "gold mine" that it has always been made out to be.

There are a number of overall trends that are making their way through to the marketplace that we will be addressing today in one form or the other.

First, there is a growing awareness that a small group marketing venture is an attractive approach to today's insurance marketplace. I have been quite surprised by the number of highly successful "estate planners," "financial consultants," and managers of large life brokerage agencies who are using small group as their primary prospecting tool. Yes, there are still far more people who talk about this marketing approach than who use it effectively. But, more and more, companies are interested in having a small group health program as an agency development tool and as a major prospecting tool for their agents. This is a very healthy trend.

Second, there is a trend toward designing programs to allow rate stability and program continuity. No program can be an effective marketing tool if agents constantly need to move their groups due to outsized rate increases,

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significant benefit reductions, or massive cancellations. Fortunately, the serious past problems caused, in large part, by a past trend towards guaranteed issue underwriting of even the smallest group seem to have run their course. There is a definite trend away from guaranteed issue to various forms of risk selection that can provide, when properly integrated into a program, the opportunity for an insurer to control its claims experience. This too is a healthy trend.

Third, insurers are recognizing that initial underwriting, of and by itself, is a necessary but not sufficient condition for rate stability and program continuity. A successful small group program must integrate marketing, initial underwriting, billing and collection, new entrants and lapses, and claims administration into an integrated flow of information in order for claims payment, renewal rating, and other renewal actions to be adequate to maintain the program's stability.

Small group programs must be administered quite differently than large group programs. An increasing number of insurers are recognizing this need and organizing their administration accordingly. Even the largest group insurers are recognizing that the special administrative handling required of small group programs does not fit into their normal group administration program. The best solution to this problem is often to turn to a carefully selected, qualified third-party administrator.

These three trends: marketing viability, initial risk selection, and administrative integration and control can be combined successfully in a saleable and profitable small group insurance program.

The panel that we have assembled represents a variety of viewpoints. I have been involved the past six years in running small group programs as both a consultant and as a company executive. Mr. Trevor G. Smith is executive vice president of Plan Services, Inc. of Tampa, Florida. Plan Services is a small group administrator which currently handles programs for twenty-two insurance companies. They have over 50,000 employers that they administer business for through those companies with over two hundred million dollars worth of small group premiums in force. Jeffrey D. Miller is a consulting actuary with William M. Buchanan and Associates, of Kansas City, Missouri. Jeff has been a consulting actuary for five or six years, having done extensive work in the small group area both with Buchanan and Associates and prior to that with Coopers and Lybrand. Sherwood Z. Smith was formerly with National Life and Accident Insurance Company where he was heavily involved with their small group program. We have tried to develop a panel that has the points of view of the administrator, Trevor Smith; the consultant, Jeff Miller; and the company actuary, Sherwood Smith.

MR. TREVOR G. SMITH: By working with a number of carriers we obviously have to deal with the multiplicity of disciplines and thoughts and processes that those carriers adhere to. This can be constructive as opposed to destructive since it gives us variation -- different perspectives, different opinions that we can bring together and benefit from. Many companies have different profitability motivations, and these have to be taken into account, but by and large they all want to operate successful programs and do them in some fashion that they are familiar with. Now there are problems in this too since they do not always recognize that small group is a substantially different business. It is called group insurance, and it is not individual insurance, but it really is not large group insurance either.

First of all, there is not a trained salaried field force involved in the marketing of small group programs. There simply can't be. There is not enough that can be put in a premium to fund that kind of activity. Most companies disallow their group men from participating in any activity of that sort and appropriately so. So the third-party administrator, in this instance, Plan Services, is heavily involved in marketing. We sell to the sellers, of course, and not the buyers. It's the seller's job to interface with the buyer. We make the job very simple for him in every aspect that we can. When it comes down to underwriting we follow the companies' practices and make them document them so that we can follow them very clearly and completely, and we subject ourselves to audits frequently to make sure that what they say in words is what we are imposing in action.

In the administrative area, as with claims, we interface with the buyer very extensively. We have a network of WATS lines that is enormous and a very large portion of our overhead, but which we feel is necessary for us to deal directly with the insureds. We try to keep the employer and agent out of the day-to-day activity simply because they don't know enough about it, don't have the staff to do it, and generally are better directed to other business activities. We have people that deal with all the questions that come up on group insurance, including helping claimants fill out forms, much as the personnel department or benefit department of a large employer would do. We, the administrators, do that and you'll find that any company is going to have to do it if they're going to do the administration themselves.

With respect to conservation, we have an aggressive approach where we contact people who don't pay their premium and ask them what the problem is. If they're mad at us we want to straighten it out so they won't be. If they think they are paying too much, a telemarketer or a conservation specialist with a CRT in front of him can tell them instantaneously what it would cost for variations in their coverage. And if they don't think they have enough benefits he likewise can tell them what it would cost to improve their plan. What this does is generate more people paying the premium they should pay. It also gives them an opportunity to consider changes in their product and also to ventilate their feeling if something has gone wrong that they can't understand or if we perhaps have made some kind of an error. It's a good idea and it's a way to get us in touch with the client so that he feels that there is someone out there who really cares about his business and about how it is going. We have even initiated a system where our people call when there isn't a problem, when premiums are paid on time, and offer to give service; to ask if everything is going all right. The response has been terrific and, since we have the commitment of people and WATS lines, our extra costs are marginal. We never do this outside the agent, and if there is a product change we go back to the agent. What we do, we do in his name and for his benefit, to keep the coverage in force.

The claims area is one that we pay particular attention to, and I think it's difficult for some companies to recognize how substantial the difference is between large group and small group in this area. For example, you simply cannot verify coverage unless the premium is paid for the period the claim occurred in. You can't guess that the premium is coming, you can't assume that you will get it from the employer, you simply have to have it in hand.

You have to condition any verification of the extent of coverage on a pre-existing limitation and it's applicability. You have to be very tough in imposing the pre-existing limitation and all other contractual provisions

and also the extra-contractual provisions that you have negotiated with the company or that the company has specified to you. We require each carrier to stipulate any such provisions in writing and we then have these visibly available to all of our people, on CRT's, so that they can see what the extra-contractual provisions are. Thus, if someone calls, they get the same answer no matter what section of the company they contact. We think this is terribly important where so many claims will be settled under provisions that are not clearly defined in the contract, such as acupuncturers or chiropractors. There is no consideration given by us because the agent has a large application pending, because he is number two in the company for the last six years, or because he happens to be the president's brother-in-law -- we simply don't take those into account. Now if the company wants to, they can have the final say. We make that clear to them as well, but we also catalog those claims and report back if there is some deviation from what the block of business should be doing because of that kind of decision. You have to be tough. You have to view it in a context that's different than regular group, where you expect perhaps that policyholder will pay his claims now or ultimately through rate changes. You really don't expect any small employer to pay his own claim. He's either going to get no return on his premium or he's going to get a substantial return, and all the premiums that you put in the pot have to be enough to pay the expenses and the claims that come out of the pot. It's all pooled and you have to treat it that way. Be very consistent and very non-liberal in the application of benefits.

If you do these things, then you can handle it well internally. Frankly, we find, and this is a self-serving statement, that it is easier for a third party to do it. It is easier for us to be tough and consistent than it is for you when so many of your people tend to follow practices that they are used to on regular group business. I might add that the application of coordination of benefits is a very significant matter in the multiple employer trust business and the small employer business, and if standards are applied that are applied to large groups it may not be satisfactory. You should expect a rather substantial savings if you apply this, but you have to adhere to it. You have to pay attention to it.

MR. JEFFREY D. MILLER: Unfortunately, a consultant in this line of business often has even less control over the total profit picture than a company actuary does. We are most often asked either to design a new program, where we really have little knowledge of the marketing force or the characteristics of the risks, or we are coming in at the tail end and trying to analyze the experience of a sick block of business that really has little hope of recovery.

Really the most important aspect of a small group program is control, and our experience is that companies that are most successful are those companies that have one man, a senior executive officer, in charge of profit -- not in charge of marketing, not in charge of being an actuary, not in charge of being an underwriter, but in charge of making money. On the most successful consulting engagement that I've been involved with, I really worked as a staff manager for the man in charge of profits. If one concept rings true, throughout my consulting experience, it would be that the man in charge of profits, the man who controls, is generally the key element in the profit picture.

As consultants we are often able to view the large problems of a line of business without the constraint of company traditions. We are able to come

in with rather novel ideas, and if nobody likes them they just fire us. It is from that perspective that I hope to talk this morning.

It seems that 1981 can now be added to the list of disaster years in the health insurance industry. With the overall rate of inflation not really extraordinary, cost shifting and improving technology seem to be moving to the fore and increasing our claims costs. The experience of 1981 brings home the point that health insurance experience must be monitored very carefully against expected norms, and all the available data must be used to keep rates up to date for both new and existing groups.

The first step in monitoring experience is projection of expected claim payments. These expected claim payments then serve as a model for comparison. In calculating expected claim payments we like to use the following variables:

1) Exposure calculated as the number of lives, rather than the premium income.

2) Expected monthly claims per exposed life, adjusted for changes in a health care index. Currently the medical care component of the Consumer Price Index is the best we have available.

3) An adjustment for select and ultimate morbidity patterns. While we have no good data on this subject, we assume that the general level of claims increases by 50% from the date of issue to the second policy anniversary and beyond.

4) A claim-lag pattern, which recognizes both reporting lag and payment lag whenever possible.

This calculation of expected claim payment is very helpful in explaining the meaning of experience as it develops, and can be quite effectively computerized.

The second step is monitoring experience on individual groups for renewal rating purposes. Small groups certainly do not generate credible experience for large claim payments. However, we believe frequency of claim is a very important indicator of the overall moral characteristics of a group. Those groups with high claim frequencies in the early policy years should probably be rated substandard for renewal policy years. While this would not completely eliminate loss ratio as an indicator of quality, we believe that frequency is much more significant in the small group area.

At the Orlando meeting Steve Cooper from Security Benefit Life said that a large portion of the bad claim experience in 1981 came from shock claims. For his company, claims in excess of twenty-five thousand dollars increased by fifty percent in 1981. I personally believe that this problem is global and political in nature, rather than peculiar to his company. Here actuaries can be monitoring the political and social developments that are likely to affect health experience. Cost shifting and rapidly changing technology can logically be expected to affect the costs on these large claims. We know of one company on the brink of insolvency because of large health insurance exposure in the state of Michigan. The unemployed auto workers seem to get sick quite easily. These types of social developments certainly fall within the actuaries' realm of involvement and those companies who anticipated them have probably survived 1981 quite nicely.

To summarize, as a consulting actuary, I see a continued need for rapid and accurate monitoring of emerging experience. A large part of this monitoring process is projection of expected claims using all potentially significant risk characteristics. In addition, we must draw correlations between social and political development and health insurance experience. These correlations can and should be reflected in rating structures without hesitation. Most importantly, day to day monitoring and control of the small group block of business is the key to future profits and sustaining profits in this line.

MR. SHERWOOD Z. SMITH: Operating a successful small group program is based on the application of many sets of interrelated factors. Initially the determination must be made as to how the program fits into the overall corporate structure. This can be ascertained from the corporate objectives for the program, providing some exist, which can include among other things an accommodation to the agency force and additional sources of income for the agents. Meeting these objectives defines success. Of course, these objectives can and do change, and the resulting definition of success will change.

Once these corporate objectives are developed and communicated, the role of the agent and sales management becomes apparent. From my experience, the role has been market penetration, profitable premium growth, and manpower development. This is true whether you are dealing with a captive agency force, brokers, or third-party administators. Other subordinate roles are good field underwriting, meeting compensation objectives, and expense management. To obtain good field underwriting you have to have chosen your agents, brokers, and third party admistrators carefully. Most that I have dealt with in trying to meet these objectives demand flexibility in the marketplace, price advantage, and benefit edge. Not design, because the design of so many of our products today are very similar. They need that competitive edge to be successful in today's marketplace. Too, the edge changes on the economic scene and today it is different from the end of the last decade. In addition, many demand more equity, with requests for non-smoker discounts, split rating areas, and special dependent rate structures. If you give them that edge they can be successful.

Once we have the business, we must see what is happening to it very quickly. Tracking product line financial results on a monthly basis by producing unit plus experience reviews of actual vs. expected results of loss ratios, expense ratios, and compensation ratios gives the actuary some of the techniques he needs to monitor the financial results. Other techniques include reviews of past rating actions, effects of underwriting actions, determination of trend factors, claim lag factors, and area rating factors. The tracking is not difficult, unless you have EDP problems; it is the implementation of needed changes rapidly to achieve the expected results outlined by the tracking and analysis that is difficult. Many times the expected results are lowered. We spend too much time correcting problems and not enough time taking advantage of opportunities to meet the expectations. To be successful you must take advantage of your opportunities, otherwise you just maintain the status quo.

Today with losses in 1980 and 1981 many companies have shifted to protective benefit designs in their health insurance lines on both new and renewal business. These take the form of higher deductibles, inside limits, lower co-insurance factors, and higher non-medical underwriting limits. Emphasis

is being placed on packaging. Additions of profitable coverages such as dental and long term disability are evidenced. Also, aggressive enforcement of COB provisions are producing savings; and peer review committees for mental and nervous claims, as well as for all other claims, are helping to hold claims costs down. Successful underwriting is important, and many companies are currently reviewing their guidelines and their experience.

The frequency of pricing new and renewal business is changing. Shorter guarantees on health insurance rates, lower life rates, and price differentials on new and renewal health insurance business are but a few of the most recent innovations. Formulas for the determination of credibility factors, as well as rating formulas, are being modified to reflect pooling arrangements. Also, development of area ratings based on HIAA or company experience, or a combination of both, are attempts to reflect more equity, and area ratings based on split zip codes are further attempts to price the products equitably.

MR. BOLNICK: I am going to open up the questioning by asking Trevor Smith if he has any comments about how the type of distribution system might affect the results in a small group program?

MR. T. SMITH: First, of course, you've got to have some way of measuring who's writing what. We try to track each individual producer's business and analyze it in the aggregate. It is very unlikely that you can do much on a per case basis but you can tell things by looking at someone's business in the aggregate. Once you know this you can perhaps take some meaningful action. We work with two basic marketing systems. One is where a company's own agents sell the product. In this instance we direct the focus on any "bad guys" back to the company and have them take whatever action is appropriate. In some cases they simply tell the regional manager or general agent that the costs have to go up for everybody in that particular area or else the agency has to stop selling through that producer. In others, they simply say that the producer is disqualified from writing the coverage anymore. In the case of brokers, our other main producing body, we track such production carefully and we take the action directly with that producer, indicating that we no longer want to do business with him.

The carriers who underwrite this coverage, in analyzing it, have found that there can be a swing of perhaps ten percent in what you would have to charge for everybody if, in fact, you can eliminate these so-called "bad guys". In some cases the carriers have gone in the other direction and identified the very good guys and given them some differential in what they can sell products for or in their underwriting acceptance practices, because that person has produced a quantity of highly successful business. So there is a difference, but it requires constant monitoring in order to make it work well.

MR. S. SMITH: In the selling area you have to pick your agents, your brokers, and your third party administrators very carefully. When you are talking about putting business on the books, the quality of the field underwriting can make the difference between profit and loss.

MR. MILLER: Trevor, I'd like to pose a question for your crystal ball. With the problems in 1981 there's certainly going to be a lot of pressure on the sales force to sell products that may be less attractive than those previously offered. How do you see the benefit structures developing to re-instill more cost reduction incentives for agents and for groups, and to

what extent do you think the federal income tax treatment and other aspects of this business will affect the types of products and the way agenst sell them?

MR. T. SMITH: Let me back up to 1981. We had some experiences in 1980 and 1981 that created some of those bad results and I think many other carriers did, too. These were specifically in the realm of no loss-no gain coverage for business coming from other programs. While it seemed that this could be done economically, it proved to be a disaster. Now, with many companies facing a mandate in many jurisdictions of no loss-no gain, some tough decisions have to be made. This has a tendency to solve itself over a period of time if everyone does adhere to the regulation, and if it is clear that there is no reason to select against your plan versus another. But if you are in any way visible as an exception, you'll get all the bad guys in the world.

The product change that we often see perpetrated by substantial rate increases involves an offer to the buyer, on renewal, that allows him to have what benefits his present premium would buy while at the same time establishing what the price would be for his present package. In many cases there will be a remarkable difference between the two products. Some of this will bring into focus to the buyer factors that he hasn't thought about before. "Cost-shifting" is not a popular term yet, although it does get some pretty good play. But when it is dramatically brought home in terms of the value of benefits related to the cost of his plan, we are finding employers very willing to accept more of the claim risk rather than the additional premium cost. So I think we will see more shift away from full benefit coverages to more limited coverages that take care of the extremes.

MS. DEBRA L. FULKS: Have you seen any changes in commission arrangements, in level commission versus high first year with lower renewal?

MR. T. SMITH: We really haven't. There continues to be emphasis on level commissions without much variation from it. We expect that in the developmental stage of new product marketing, such as with universal life and the like, there may be higher first year commissions on such business as opposed to a flat commission on it. But historically the emphasis has not been on graded commissions.

MR. S. SMITH: I would think that with the way the premiums are increasing we'll see the commission amounts increasing substantially, assuming the percentages stay the same. This leads to a question. Could the percentages be reduced to yield roughly the same or maybe a slightly greater commission level? Do you think that this would be acceptable?

MR. T. SMITH: Only if you did it first. I'm afraid it is one of those circumstances where until some major leader in the industry does it, it is not going to be acceptable to the seller base. They don't perceive that they get any less than they should or that they should get any less than they do.

MR. DEANE NINNEMANN: The question I have is directed at companies who are using primarily their own agents to market their products and the problem with deteriorating credibility, where the agent went out and sold the business on the basis that he has a program that wouldn't later cause him embarrassment and trouble with the client, and where the company was late

forced to raise premiums or reduce benefits significantly. I would like to ask if you have any comments on dealing with agents' relationships with the home office under such conditions?

MR. T. SMITH: First, it is important that any time you develop a program for a company that's going to be distributed through it's field force, that the field force be represented in the process. As a consequence, we have involved advisory groups of agents and general agents in the development of such programs. This helps considerably when you run into that kind of a problem. It also gives you an opportunity to tell the agents in advance that there is no such thing as group health insurance without rate increases. We find companies very willing to participate in educational programs and in distributing information and helping agents have articles and facts that they can take to their buyers in advance of rate changes, indicating why the rate change is occurring and that it is not necessarily peculiar to their company. Thus, while there may be credibility lost, the credibility is that of the entire marketplace and not just with their company's own product.

MR. STEPHEN N. STEINIG: In identifying an agent who has given a company bad business, and where the company might be thinking about dropping him or refusing to accept small group business from him, is there a minimum number of cases that you would use as a benchmark? For example, an agent with ten cases in force is an agent who has given us a lot of small group business, and yet ten cases averaging four or five lives is still not a body of data which would be regarded as having any credibilty in the normal way of thinking. It is a dilemma for us as to what to do and I am curious about exactly what you have done.

MR. T. SMITH: Usually, when you have an agent that has ten cases, what you spot isn't just a function of the loss ratio. There may be a concentration on businesses, such as hairdressers, barber shops, or gas stations, where one or two wouldn't be bad, but ten out of ten is terrible. What else is he selling them, and is there any correlation between that and the production that you've seen in the ordinary side to the same buyer? We do find, though, that frequency of claim may be the biggest indicator where there are six or more cases. If we find that there are a lot of first year claims on cases brought to us by a producer, we have a pretty good indication that that producer is bringing us business where he knows the quality is less than good, and perhaps he is even soliciting on that basis. We don't obviously say that to him or his company, but there is a suspicion of it. What we do then is pull out the history on every claim that has been submitted. By doing that, it honest-to-goodness jumps off the page at you. You can see the kinds of things that have occurred, something that just shoots right at you and tells you that that person has selected and is in the practice of selecting against you. The dollars can be misleading, and in fact if we look at six cases the person may have a paid loss ratio in excess of one hundred percent at the end of the second year that he has produced business, and it doesn't mean a thing detrimental. But there are patterns that tend to follow if you look at half a dozen cases or more.

MR. BOLNICK: The issue here, from an actuarial point of view is one of credibility and what it really means. Patterns emerge that aren't credible in a statistical sense, but that really do tell you about the agent or a piece of business. Statistical credibility is simply a mathematical formulation and it assumes that you don't know anything about a specific

risk. But if you know the claims, if you know the problems on a given case or with a given agent, it really doesn't take much to figure out if the guy is sticking it to you or not. These people stand out like a sore thumb and all you have to do is look for them.

MR. S. SMITH: Do the bad guys ever turn out to be the good guys?

MR. T. SMITH: Not in my experience. They really don't. In fact they tend to go into aluminum siding or screens usually.

MR. DAVID BAHN: Do you see any change coming in the commission structure so that we might have different commission structures depending on plan type? For instance, a limited benefit plan with a higher commission level than a wide open, more comprehensive, full benefit plan.

MR. S. SMITH: I would say the answer to that question depends on the strategy of the company. Normally the amount and the percentage of commissions paid are a result of the objectives that your management has set up, and if management wanted to direct you to a given product they certainly could do that by changing commission scale. In the products that we have developed we have increased our commission scales to our agents because we wanted those products sold, and I'm sure it would be possible to go the other way.

MR. BAHN: Trevor, you started off by saying that you don't see any salaried home office group reps. involved in the marketing of MET's, but from your description of the kind of activities that you do as well as what you encourage a company's home office staff to do, it seems that someone is still incurring the expense of those activities which I would call group rep. activities. If this is true, then you have the same type of expense in your pricing as you would have in a typical true group.

MR. T. SMITH: That is a good observation. The people that we have doing this we call telemarketers. Their capacity to reach an audience is infinitely enhanced over that of a group man because they can go directly to the seller, and in some cases to the buyer after the product is sold, via WATTS lines, much more frequently and easily than the group man who is doing it off the street. There is never face-to-face contact with either the seller or the buyer, so the costs are substantially less per unit of service delivered. I would say the difference is basically that you can get far greater results and have better control by having such functions centralized in people who are completely in your view, and who deal simply in WATTS line activities.

MR. BOLNICK: I would like to ask Jeff Miller if he has any comments on how various forms of initial underwriting might effect small group claims experience in the first year or two.

MR. MILLER: There are two forms of underwriting that have traditionally been applied in the small group market. The first would be risk selection, that is, choosing groups that are going to be good groups as opposed to those that are going to be bad. The second and probably the prevailing underwriting tool has been the pre-existing condition exclusion. Much of the good claim results that we get in the early policy years is the result of contract provision and not risk selection at all. As has been mentioned, however, this pre-existing condition exclusion is slowly slipping away through no loss-no gain requirements. Thus individual underwriting and risk

selection are going to be moving to the fore. As we go forward, consideration of individual risk characteristics will become much more significant, and the only way we will be able to do this is through sophisticated data processing facilities that can analyze the data on an individual basis and still stay within the expense margins available on a group contract.

MR. WILLIAM BANDY: What data? What are you going to get on a three, four, or five life case that tells you anything? You'll get perhaps the industry they are in. You can't get any meaningful data on past experience on that particular little unit.

MR. MILLER: I think the short form medical questionnaire is one source of data. I think that field characteristics are another source. Aside from that, the best you can do is try to get some indication of which groups are going to have people with pre-existing conditions and simply throw them out.

MR. T. SMITH: We have tried many different approaches, none of which are perfect. Some work better than others. We've tried no questions and just imposing the pre-existing conditions limitation, which means that you underwrite only claimants. Hopefully there are fewer of those than there are insureds so there is a lower cost involved, but it is still hazardous at best.

Second, we tried letting the employer be the field underwriter, and we asked him specific questions on a "to the best of your knowledge basis". These fell in the realm of: "Has anybody been rated or declined for previous life or health products applied for?"; "Has anybody had five thousand dollars of claims in the last two years?"; "Is everyone really at work?"; and, "Are all the dependents that you know about healthy and well?". These are really disqualifiers more than qualifiers. They simply mean if the guy says no he knows he better go someplace else to get the coverage. It gives the agent an opportunity to ask these questions in advance and not find out about some problem later. The old resources of retail credit are not satisfactory. They don't give us any information. We have now moved to an array, in one of the companies, of different kinds of questions asked specifically of the prospective insured, or in many cases, of all the people that will be in the program. We again ask rather basic questions that relate to recent treatment or hospital confinement or known disabilities, and we do have black or white underwriting on those questions.

Taken to the extreme, some companies have an eight and a half by eleven two-sided form that you have to complete in detail. I took one of those, replicated it, passed it out to a dozen people in my company, and said, "Complete this please in detail and, as a last fact, put down at the bottom how long it took you to do it." All of the people were in different sections of the company and doing different things. None of them really were insurance people, they were consumers. They completed it, and the range of completing it was everywhere from some short period like 12 to 15 minutes, to two hours. To tell you the truth I couldn't complete it myself on site. It asked every treatment each of my children had had in the last five years and I'm blessed with a lot of children and they are blessed with a lot of bumps and bruises. I couldn't possibly complete that without having my tax record. That's too much, this type of questionnaire doesn't help you.

The answer to the question is that you don't look at claims experience. You look at the kind of experience a company has had in terms of its turnover of

people and the salary levels and job classifications of the people who are applying. Then you ask specific questions about the participants.

MR. S. SMITH: In the area of pre-existing conditions, certain types of limitations will certainly result in better claims experience. From the marketing standpoint, if you have limitations, then the agents like to have these waived, and you have to come up with a price for waiving them. I wonder how companies are really measuring the value of these additional benefits as they are going to no loss-no gain or to waiver of pre-existing conditions. There is an additional cost associated with it. If you are changing your medical underwriting rules from five or six lives to ten lives or even fifteen lives, as some companies are starting to do, what kind of impact is this going to have on your claims cost?

MR. BOLNICK: In the session in Orlando there was a lot of discussion about one of the problems just alluded to, and that was bad experience at the break point in underwriting. A number of people commented that when they went to guaranteed issue for six lives they would get bad experience at six lives, and when they moved up to nine lives they would get bad experience at nine lives. There were always attempts to make up groups to avoid more stringent underwriting requirements. This fits the pattern that we have seen, too. Overall this question of underwriting is a very difficult one. What you are trying to do is balance saleability with profitability and get the most "bang for the buck". You can always go overboard. You can always ask an eight and a half by eleven page full of questions. You can always go with an MIB, with an APS, with an inspection report. You'll have all the time in the world to do it, because you will never be selling anything. On the other hand, you can go to the simple guaranteed issue with no review and there you have your problem solved, since you are not going to look at anything, just accept claims.

MR. DAVID L. CRESWELL: I'm being told by the people at our company that sex distinct rates for health insurance on multiple employer trusts are really not a good idea, that very little of it is done in the industry, and that when you do send these rates out to the units in the trust you run into a lot of problems with people screaming discrimination. I would like to get some feedback because I'm beginning to suspect that this is not true, that there are a lot of companies with different rates for male and female.

MR. S. SMITH: In developing your rating structures for, say MET business, certainly you are going to look at your claims cost by sex and also by age. From a marketing standpoint what you are going to do is probably make some assumptions about the composition of your MET and from that standpoint you will come in with a rate that which does not show separate male or female values. This is probably more true on the employee side than on the dependent side, because on the dependent side I see a need for specialized rate structures which more adequately than in the past reflect the dependent composition of the MET.

MR. T. SMITH: I would say that the tendency or the trend now is toward sex distinct rates. I am inclined to think that you are correct in saying there will be increasing pressure and probably some validity to including separate rates by kind of dependent structure. This approach does measure the risk more accurately. Its saleability is all right, and as long as the computer keeps track of the extra banks of premiums that you need, it works.

MR. S. SMITH: On the employee side, do you see just employee rates or are they going to male and female rates?

MR. T. SMITH: They are going more and more to male and female.

MR. BOLNICK: I haven't seen or heard anybody who went to a flat employee rate or flat family rate because of pressure from sex discrimination laws. There is plenty of data to demonstrate that females are more costly than males. Most of those decisions, as far as I am aware, have been made simply for administrative ease.

MR. KEVIN KENNY: I think it was Jeff who mentioned that in assessing the desireability of a group, claim frequency is a better indicator than loss ratio. Could he explain why that seems to work even though loss ratio is a lot more closely related to bottom line than claim frequency is?

MR. MILLER: You have to consider what it is we are covering here. A very large claim is the responsibility of the insurer. That is what we are selling a product to cover. So you need to throw those large claims out. What we are really trying to underwrite is a moral hazard. We are trying to pick out the group that goes to the doctor every week. The large claims may blow your loss ratio out of the water, but the small claims are the ones that, over the long haul, are going to cause you to have a bad block of business.

MR. BOLNICK: There is a tendency for actuaries to try and figure out how to get a nice beautiful mathematical formula to determine what are good and what are bad cases. I don't believe that can be done in small group. The only way you can tell a good case from a bad case is to take into account not only loss ratios and frequency, but more than anything, individual claim detail. A bad group will stick out like a sore thumb. It may be a group that has a very low paid loss ratio, but if a group is six months old and you have a claim in there for a doctor's visit for coronary artery disease, and you have had mental and nervous claims, and you have diabetes on three lives, you had better believe that it is a bad case in spite of the low paid loss ratio. There is no substitute for knowing what the claims are for on a group basis. Many companies have tried the idea of throwing out all groups with loss ratios over 100%, and the next year they are no better off than they were before, because they threw out all the bad ones this year but then they had a whole new set the next year. This is one trap that I think is all to easy for actuaries to fall into; thinking that they can press a button and get the computer to solve their problems for them. It really doesn't work.

I would like to turn our attention now to claims and start out by asking Trevor to expand on his comments about the difference between claim payment operations for a major group versus a small group.

MR. T. SMITH: One matter that concerns me, and that I haven't been able to resolve with many of the companies we work with, is how you apply reasonable and customary determinations to the payment of claims on small employer groups. The kinds of standards established for large group really do anticipate that you are trying to catch a flagrant abuser, in other words a doctor who is charging an outrageous sum. By applying studies such as the HIAA, particularly if you are not in many metropolitan areas, you may end up using a very high percentile as a reasonable and customary, and seldom

challenging a claim. I'm not sure that you, or we at your direction, are challenging enough of them. My request of the companies is that they lower the percentile substantially, below what they use for large groups. It doesn't necessarily force the insured into paying more of the claim, it forces the physician into accepting less dollars, which may be appropriate. We have had some trouble in negotiating this with companies where we have a substantial impact in the community, for example, where we are distributing a lot of dollars to the hospitals in the community. The carriers are not interested in having us try to negotiate any kind of a discount. The feeling is essentially that if you are against Blue Cross getting a discount, you shouldn't participate in it yourself. I don't happen to subscribe to that. The group health business is very fragile, but the small group business is particularly fragile because you don't have anyone to hold accountable for it among the buyers or the sellers. You are accountable for it yourself and you really have to distribute the money with a great deal of caution.

The other matter that I mentioned, about watching the contractual limitation and being very strict in the imposition of pre-existing condition limitations, happens more often in this business than in large group. You have an awful lot of brothers-in-law, uncles, and cousins that employers think are okay to put on the plan until you point out to them that it isn't. And because you don't check addresses on enrollment cards, you don't really know that they are living some place in Oregon when their case in located in Georgia until you get a claim. It becomes very difficult to impose the fact that they can't have coverage under the program, and to return the premium, but you simply have to. It is not discussable. The system has to be set up to do that. Companies that have paid claims themselves through regional offices have had tremendous problems of overpaying claims, and it is largely because people are use to paying claims on large group cases and can't come down to the very strict adherence to both policy and administrative position that applies in small group situations.

MR. GERALD S. PARKER*: Has anyone noticed an increase in the practice of hospitals loading up on miscellaneous charges, like pharmacy, particularly in states such as Connecticut and Maryland, where they have prospective rate filings?

MR. T. SMITH: Yes. The difference between total aggregate cost of room and board vs. the cost of miscellaneous services is getting further apart all the time, with miscellaneous outstripping room and board charges. There is certainly evidence of pharmacy abuse, where they dispense packets of pills but only a small portion of that quantity is really needed for the patients use, and they presumably dispose of the rest. Disposable business in hospitals has become a giant business. Everything is disposable, evidently, except the patient. There hasn't been a good way of curbing this, short of saying we simply won't pay it, and in many cases we do just that. When the miscellaneous bill is excessive, we simply go back and pay the hospital what we think is an appropriate reimbursement. Often the hospital doesn't respond, they simply accept our payment.

MR. BOLNICK: When you are determining your area factors, you have to keep in mind that hospital room and board is only a piece of the hospital bill

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and that there are wide differences by state in how the mix between room and board charges and miscellaneous charges shows up on bills. If you are making all your area ratings based simply on room and board differences you will find yourself out of line in many areas.

MR. WILLIAM BANDY: At the Actuarial Club of the Pacific States meeting this topic was discussed and the subject of claims control got some comments. Merely doing the arithmetic on the hospital bill by adding up the number of days in room and board charge had saved one company something like 15% of their actual payments, just in pure arithmetic errors. There is a company that I am aware of in San Diego that employs RN's and that works primarily with self-administered groups. They will pick up from the original request from the hospital for verification of coverage, and go in and work with the records at that point to make sure that the guy with the sprained knee isn't in there for three months just because he has no place to go. Have you noticed, or are you utilizing with any success, this type of claim control?

MR. T. SMITH: We have used this and audit procedures of all different varieties with very little success. We find that the facts are presented to us after the treatment has been supplied, and we don't get the statement of claim for weeks, maybe months after it's supplied. When you go back and audit, you will find that all the services and all the pills are recorded as having been delivered, even though it would be impossible for anybody to consume them all. Very seldom have we been able to put pharmacist to pharmacist and say, "Why so many? Why this often?", and then have the pharmacist or hospital reduce the charges.

MR. ROBERT D. HARDEN: With regard to the employer acting as agent for the insurance company, we have courts in California that are saying that, if the employer has delivered a certificate to the employee and the employee has made his contribution to the employer, then you cannot deny a claim for that individual. You indicated that for small groups you need to be able to deny that claim, and strictly enforce the literal terms of the contract, regardless of whatever expectations might have been created by someone who is legally your agent.

MR. T. SMITH: What we are trying to do is to establish that there is a rule and it has to be applied. Therefore, if someone has not paid the premium and a claim occurs, we don't reimburse the claim. If it goes to court, the company will make a decision as to whether they want to defend that position. However, there are an awful lot of them where either you get the premium, because the person had put you at the bottom of his priorities instead of the top, or deny coverage because the employer has gone defunct and did not subtract the employees' portion and collect the premium on behalf of the program. In fact, we often find that he has gone to another program and that this is a claim filed with two carriers.

MR. HARDEN: In Oregon, it is very clearly an unfair claim practice to deny a claim that you know you would pay if you went to court over it.

MR. T. SMITH: We don't consistently pay them when we go to court over it. In fact, we don't go to court very often. It is a tool that gets your premium collected more often than anything else. The contract that we operate under simply allows the employer thirty days to pay his premium, but does not say that he has coverage during those thirty days. So, if he doesn't pay it ever, his coverage is terminated at the beginning of the

period. This is a fine point and I don't think we want to get into it, but it does support our position that we don't intend to pay those claims under court direction or otherwise unless the court determines that there are circumstances that we don't know.

MR. BOLNICK: I would like to ask Jeff Miller to comment on the need for renewal underwriting and what he sees happening with it.

MR. MILLER: I have talked with carriers who have said that a multiple employer trust, as a block of small group insurance, has a limited life and you can only sell it for five years or seven years. Then you have to cut it off, let it run itself out, and have a new fresh block of business to sell on the street. I have a few problems with this approach. I think that a block of business can be maintained on an ongoing basis if you recognize the characteristics of the groups as they emerge, and renewal underwriting is a big part of this. The people that we have worked with who are trying to implement renewal underwriting programs use a tier rating approach. They have one set of rates for new issues and then, at renewal time, they analyze the frequency of claim and the participation requirements, and put the renewal groups into a set of tiers. There are some obvious ethical questions and maybe some regulation questions as to what the various states will allow you to do, but as we go forward we are going to see more renewal underwriting and more consideration of actual experience for the smaller group.

MR. BOLNICK: There are basically two things which are important to bring out if you want to develop a successful, profitable small group program.

The first is that small group administration, from start to finish, is not the same as for large group. One consistent mistake I've seen made in the marketplace is for people to try and treat it just like one big, large group. It won't work. You need to develop specialized systems and you need to work with special people who only deal with small group, either in your company or through a third party administrator.

The other key can be summed up in one word and that is "control". You have got to control your business. You have got to know what is going on with every participating employer unit. The companies that have been successful with small group are the ones who control it.