RECORD OF SOCIETY OF ACTUARIES
1982 VOL. 8 NO. 4

MANAGEMENT STRATEGIES IN TODAY'S GROUP INSURANCE ENVIRONMENT

Moderator: PAUL R. FLEISCHACKER. Panelists: PHILIP BRIGGS, JAMES D. CHAPMAN, RONALD L. WOBBEKING

1. Profitability - can it be? Reasons for 1981 gains and losses.

2. What strategies are being considered or implemented so that a company might operate more effectively and profitably in today's environment?

    a. Coping with economic cycles
    b. The cost shifting problem
    c. Organizational structure
    d. Administrative requirements
    e. Marketing strategies
    f. Product design and costs
    g. Other

MR. PAUL R. FLEISCHACKER: Before proceeding with the presentations of the Panel, I want to spend a few minutes discussing the general planning concept and, in particular, organizational planning. As you will quickly note, this concept can be, and should be, applied to management strategies in today's Group insurance environment.

Organizational planning can best be illustrated by a two-dimensional model. On the one side of the model are the "strategic" elements, and on the other side "organizational" elements.

All of the elements are interrelated and each must support the other elements if the organization is to achieve optimal effectiveness. A change in one element usually signals a need for adjustment in one or more of the other elements.

The "strategic" elements of the model represent a set of variables which are common to all companies: environment, objectives, and strategy.

Composed largely of external factors, environment includes:

- Legislative and regulatory requirements
- Legislative changes
- Economic conditions
- Industry concentration and characteristics
- Competitive conditions
- Industry and/or social trends affecting the organization

Environmental analysis should precede strategy formulation since it is the variable over which a company has least control and which, in many ways, defines the limits of what is possible for the company to do.

Objectives are the goals a company sets for itself. Strategies are the means by which the company intends to achieve its objectives.

Taken together, environment, objectives, and strategy determine a company's critical success factors. These are the things it must do well in order to achieve its goals. These factors may include:

- Product innovation
- Expense control
- Increased productivity
- Cash/investment management
- Expansion/acquisition

As with the determining elements, the critical success factors are not static and must be changed to reflect changes in the determining elements. Also, there is no absolute list of critical success factors. Each company will have its own.

On the other side of the model are the "organizational" elements which include:

- Organizational structure - the important item to keep in mind regarding organizational structure is that, while there is no absolute correct structure, an appropriate structure will support the corporate mission and strategy and also reinforce the other organizational elements.
- Organizational resources which include:
    - Human resources
    - Financial resources
    - Physical resources
    - Technical resources
- Organizational culture which is an amalgamation of history, beliefs, values, norms, and traditions of a company. Culture is a powerful, persistent organizational element, and one that can inhibit or support strategic change.
- Systems which impose order and methodology and are meant to conserve energy and promote efficiency. The more complex an organization, the greater number of systems it will have, such as business planning, data processing, financial control, communications, management information and many more.

The "organizational" elements shape and define a company's distinctive competencies, that is, what it does well. These elements, individually and

collectively, are what must be altered to develop new competencies or to modify old ones when they are no longer appropriate.

Finally, too often, when a company fails to reach its objectives, management blames the strategic plan without searching deeply into the reason for its failure. Because of their complex interrelationship, analysis and evaluation of all the elements in the model, "strategic" and "organizational," are necessary in order to determine the reasons and potential solutions.

MR. RONALD L. WOBBEKING: The article, "The Group Insurance Myth" by Peter D. Walker published in 1977, analyzed profit and growth of Group insurance and whether or not they were mutually exclusive. The conclusion reached was that they were not mutually exclusive. Times have certainly changed. The subjects are still the same but now the question seems to be, "Are either profit or growth possible?"

With that as a backdrop I would like to tell you what my company, North American Life and Casualty (NALAC), has done in the last seven years in the way of developing and implementing a marketing strategy, as well as to give you some of our operating philosophies. In addition I would like to briefly relate the results we have experienced during this period of time.

NALAC's Group operation was begun in the late 1950s in order to provide our Individual Career Agency System with an additional product line. Through evolution, we supplemented this distribution system with a substantial brokerage distribution system. As is typical in a brokerage dominated distribution system, we became very price and product conscious. Our results were very cyclical. Periods of prosperity, usually from substantial sales results (which disguised an underlying problem with the in-force business) were followed by periods of loss and retrenchment. Instead of having a defined marketing strategy, we were trying to be all things to all people. Some companies have the facilities to operate this way; we did not. NALAC does not have the name recognition that Prudential, Aetna, Metropolitan, Travelers, or any of the other large writers in the field has in the marketplace. They write business not only because they are very good at it, but also because they are there.

It became obvious that we needed to find areas in which to specialize in order to survive and prosper. As a result, we began to develop our marketing strategy around specific market segments, confining our attention and energies in order to become very good in these defined markets.

Before I talk about the particular market segments we identified, I would like to briefly describe how we approached the development of our marketing strategy. Any marketing strategy needs to answer three types of questions.

1. Who are you going to sell to? What is your market? Who is your consumer?

2. How are you going to reach the market? What distribution system will you use?

3. What are you going to sell? What products do you want to offer to your chosen market?

One additional type of question needs to be addressed, but it is much more difficult to answer. Why will you be successful? Why will the chosen market and distribution system accept you in the marketplace?

It would be nice to say that we sat down and consciously asked ourselves these questions and then selected the appropriate markets, distribution systems, and products we would use. However, as you are all aware, the real world does not operate that way. The process is evolutionary - not revolutionary. We reviewed the areas in which we were operating, our strengths and weaknesses, our objectives and our results, and selected those markets which we felt were best suited to us. We were also faced with the need to decide on what we would do with the business that was not consistent with our chosen marketing strategy. This led to ceasing activities in some areas, and terminating blocks of business in other areas, such as the METs. Needless to say, those actions strained some relationships, including, because of the ultimate distribution system we selected, those with our Individual distribution system. The process, as you can imagine, involved some delicate management issues.

As a result of the overall review of our operation, we selected the Association Group, and the Self-Funded, Stop-Loss areas as markets we wished to penetrate and selected Broker/Administrators as the distribution system we wanted to use to reach the market. In doing so, we had to change our orientation from "price and product" as dictated by a brokerage distribution system, to "market and distribution system."

Our initial definition of the Association Group market consisted of professional associations, primarily national in scope, which are solicited through the mail. This market, for us, is now expanding to include nonprofessional associations (i.e., more loosely defined formations of people with common interest, such as alumni, credit card holders, and magazine subscribers). In addition, we have recently entered the Trade, or small employer, Association area. Originally we dealt only in the sponsored market; sponsored meaning that the association endorses the program. We now see potential in the non-sponsored area and are pursuing opportunities there.

The distribution system we chose to penetrate the Association Group market segment was a small select number of Broker/Administrators, whose function is to seek out prospects, determine their needs, and perform the majority of required administrative services. These administrative services include:

1. The preparation, printing and mailing of the brochures used (with NALAC's prior approval of the content) to solicit the members.

2. Receiving the applications from prospective insureds and forwarding them to NALAC for underwriting.

3. Issuing our certificates or individual policies for those insureds approved by NALAC.

4. Preparing and mailing premium notices to the insureds, collecting and remitting the premium to NALAC.

5. Verifying coverage for individual insureds and either paying claims or forwarding claims to NALAC for payment.

6. Maintaining all necessary accounting, administrative, and statistical records.

7. Cooperating with NALAC in the auditing process.

8. Posting bond as required.

The basic product line that we offer in this market is Life, Hospital Income, Disability Income, Medical Supplement, and AD&D. I will discuss the concept of "product" we use when I discuss our operating philosophies.

In the Self-Funded, Stop-Loss market our major thrust has been in the experience rated area. Our target market has been employers with 200 or more employees. We operate through a limited number of Broker/Administrators whose responsibility includes the sales effort, as well as providing the administrative services for the employer and NALAC. These administrative services include:

1. Receiving Group insurance applications and initial premium, forwarding them to NALAC for underwriting.

2. Distributing policies and certificates.

3. Maintaining appropriate accounting and administrative records.

4. Paying claims for the underlying employer plan.

Some of our Broker/Administrators, after an additional very stringent audit and approval process, are given draft authority. We require receipt of monthly claim status reports and special reports for each of their accounts, as well as information for individuals whose claims reach a predetermined level. This enables us to keep abreast of claim experience, and to establish our reserves. We also perform scheduled audits of an Administrator's claim-paying operation and his accounting functions on an annual basis, or more often if necessary.

Our Self-Funded product line includes Stop-Loss coverages, as well as Life, AD&D and Disability, both short and long-term. The Stop-Loss coverage we offer is a reinsurance policy for the employer and not an insurance policy for the employee.

We also operate in a third market area which we call Special Markets. As this name implies, this is an area in which we look for additional marketing opportunities which can either provide a substantial source of income or exposure to potential additional market segments. For example, we have worked on joint ventures with other insurance companies where our expertise in our market segment is made available to other companies, or their expertise is made available through our organization. We have also been active in reinsurance with other companies and in participating in reinsurance pools.

Our marketing strategy is in written form and is distributed to all our personnel, so everyone is aware of our objectives as a team. We review the strategy annually as a prelude to our five-year planning process, but the actual strategy guides our daily lives.

We reorganized our Department to be consistent with the marketing strategy developed. The market segment concept has been carried throughout our entire Department. Our Actuarial, Underwriting, Sales, and Administrative areas are all organized along these market segment lines. As an example of the changes our strategy created, our Claims and Administrative areas function more as auditors and consultants than as processors and administrators. Since we deal only with a small number of professional Broker/Administrators, the need for our Branch Office system was eliminated. This allows us to operate exclusively out of the Home Office for all decisions.

The truly unique characteristic of our organization exists in our marketing area. First, however, I would like to comment on "marketing" versus "sales." We have developed a tendency in the industry to use the words "marketing" and "sales" interchangeably. This is a mistake and is seriously misinterpreted in and outside our industry. Sales is only one - albeit vitally important - element of marketing. Nevertheless, our marketing area includes both the sales and underwriting functions.

The key to our operation is our marketing managers. They are responsible for developing the relationship with our Broker/Administrators, our production and profit. Our actuaries and underwriters are there to provide the marketing managers with advice, input and guidance. Marketing managers have complete authority to make decisions - within the parameters of our marketing strategy. In other words, they have full authority to accept or reject a risk at a rate they establish. In the beginning, this created some resistance from our underwriters and actuaries and, I might add, some concern by myself. Our marketing managers had not necessarily performed in a sales capacity prior to being put in the job, but all had previous insurance experience, including some with an underwriting background.

However, the key factor in this type of organization is the motivation provided in our compensation system. Our compensation system for the marketing managers is built around a salary, plus incentive. Our base salary is competitive in the marketplace. In addition, we have a high potential for incentive bonus. However, there is no incentive bonus paid to any marketing manager unless the entire Department meets or exceeds the minimum profit objective. Basing the compensation on total Department results provides a much better team atmosphere as well as a certain amount of peer pressure. The profit objective that we initially developed was a minimum pre-tax profit of 4 percent of earned premium. Therefore, in order for a marketing manager to qualify for incentive bonus, the overall Group Department's profit must first meet this objective. Incentive compensation is then based on the total Department's profit and growth as well as the individual marketing manager's production. It has not been unusual for our incentive compensation to be an additional 50-100 percent of salary for those who perform at high levels.

The answer to the last question in developing a marketing strategy - "Why will the marketplace and distribution accept you and your products?" - is answered at NALAC by a discussion of some of the philosophies we use in our operation.

1. Profitability is our first concern in any potential venture. We are very frank in our discussions with our administrators concerning our objectives. They and all of our personnel are well aware of our goals and what we expect from administrators' block of business in contributing to our results. You would be surprised at how few companies discuss profitability with their producers. I am also amused at the prominence that profitability plays in publications and discussions, depending on the existing economic climate. In the good times we talk about consumerism and equity; profit is a dirty word. In the bad times, survival through profitability is in the forefront. I am reminded of a quote from Fran Tarkenton, "Business is a game and games are fun. To me, profits are like putting points on the board."

2. Renewal underwriting is the key to our success. Since all of our business is written on an annual renewable basis, we, in effect, re-underwrite our total book of business each year. We can afford to make some mistakes in writing new business, but we cannot afford consistent errors in our renewal efforts. The re-underwriting of our total book of business each year is of much greater significance to our financial results than the underwriting results of new business alone.

3. We also have a very strong belief that the insurance business is a people business. An average plan well executed is better than an excellent plan poorly executed. Our success will depend largely on not only the quality of the people in our organization, but also the quality of the people with whom we deal. We are believers in training and developing people. For example, we require all of our marketing people to participate in industry educational programs, such as HIAA and LOMA. We also urge our administrative people to participate in those programs.

4. We consistently remind ourselves that we are in the insurance business. We are not in the administrative business or the investment business, as primary activities. It is, therefore, our desire to be the best possible underwriters of insurance. We feel the business of insurance centers around risk-taking and not in the administration of those risks.

5. We are not product oriented. Our customer is the Broker/Administrator. His responsibility is to determine the needs of the market and to come to us with those needs. We do not presuppose the needs of the market. The administrator comes to us with what he wants to offer to the market and we respond to those requests. We, therefore, do not have shelf products that we market but try to be flexible in response to market needs.

6. We are book underwriters. We review the administrator's total book of business in our day-to-day dealings with him. Our review is aided by statistical information which we maintain by administrator. We work with our administrators to solve their problems. Because of this, we

are not a manual or rule oriented operation. Our manuals are only used as guidelines and are not allowed to be used as the sole reason for not doing something. We always seek ways to do things.

I have a little speech that I frequently give to our technical personnel - the lawyers, underwriters, and actuaries. The three major tasks that they have as I see it, in reverse order of importance, are:

- Cet us out of trouble if we get into it.
- Keep us out of trouble.
- Tell us how we can do things; not why we can't. We feel that those who say it can't be done should get out of the way of those who are doing it!

7. We strive to build a business relationship between us and the Broker/Administrator. For example, in the Association Group market we either share in the promotional costs of a mailing, or if we finance it, we require a long-term commitment on the business produced, providing an opportunity to recover our acquisition costs.

8. As I mentioned earlier, we have carefully targeted specific markets through limited distribution centers. We have maintained a consistent approach, but with the flexibility to meet the needs of the marketplace. Our strength is the fact that we have targeted our markets and provided quality, and reliable and consistent service to those markets.

9. The incentive programs for our personnel and any financial arrangements with our administrators are defined to be consistent with our goals and objectives. This may seem obvious, but there are tremendous numbers of companies which have incentive programs that pay for performance that may not be in the best interests of the company as a whole.

10. We follow the philosophy of terminating nonperformers early. As basically stated by our keynote speaker this morning, you should be careful not to confuse activity with results. The question is not how much you have to do, rather, how much have you done? This philosophy is carried on not only within our operation but also with our administrators. We make our entire organization, including our actuaries, underwriters, lawyers and claims people, available to the administrators. We, therefore, cannot afford a large number of nonproducing administrators absorbing the time of our professional staff. We look for our administrators to have the potential to generate substantial premium in a relatively short period of time.

All of this sounds excellent, but what have been the results? Seven years ago, in the process of reviewing our marketing strategy, we chose to eliminate approximately one-third of our in-force business, including all of our traditional medical business. Since that time, and through 1981, our compound growth rate for earned premium, starting from a base that was substantially reduced by one-third, has been approximately 25 percent; and in the last couple of years has been in the 40 percent range. Our overall

net profitability has averaged 7 percent of premium. Our sales growth has increased at a compound rate of 30 percent. Our best results have come in the last two years. So far, 1982 looks like it will be our best year ever. Our plan appears to be working.

However, too often I have seen that success breeds overconfidence. This can lead to disaster. The marketplace and the economy do not leave much room for overconfidence. We monitor our business closely and frequently and are not afraid to either terminate the nonperformers or take appropriate corrective action, even if this involves loss of substantial business. Our objective is to make a profit! Only through this can we continue to provide value to the consumer and a reason to remain in business.

At this point I would like to comment on a couple of other items that are germane to "Management Strategies in Today's Group Insurance Environment."

First, let me discuss planning. We spend a great deal of time in planning. Our plans are developed on a five-year basis and are updated annually. The process is performed during the Summer months, and the first year of the five-year plan forms a basis for the following year's budget which is completed in the early Fall. The five-year plans for the Marketing Division, both Group and Individual, are completed first and are formally presented to the Elected Officers at a one-day meeting in early Summer. After all the company Divisions have completed their plans, a three-day meeting, again of all the Elected Officers, is held to discuss the plans in depth. In addition, our Corporate Planning Committee reviews in detail each Division's plan with the Division Head.

In the planning process for our Group insurance operation, we develop a list of objectives we want to accomplish over the next five years. These objectives relate to profitability, growth, expenses, and human resources. They are very specific in nature; an example being the targeting of a specific rate of growth in our earned premium and new sales, as well as setting a target for our overall expense ratio. Planning, however, does not assure success.

Second, I would like to touch on profitability, which includes pricing and coping with economic cycles. As I said before, the major factor involved in operating profitably is in the renewal process. It is all too easy to operate in a reactionary manner. In other words, action is not taken on renewal until the experience has reached a level that will justify action. The environment in which we operate tends to generate this position. Typically the underwriter must convince the company sales representative, who must convince the broker, who must convince the client that a change is needed. Three of the four parties involved are resisting this change.

This activity creates two problems. First, the selection process of writing new business, as limited as it may be in some cases, will create initial experience more favorable than ultimate experience. The result of this is to delay appropriate action on renewal. Second, the process of selling an adjustment normally delays implementation for a period of time. I believe the forces operating here are best exemplified by activity in the METs field. The problem, simply stated, is rate increases have not kept up with cost increases. This generally results from delayed action since ultimate experience is disguised by selection and growth, and deferred by the process

involved in selling the increase. As we all know, this leads to the next problem which is large increases, which involves anti-selection, and the proverbial vicious cycle.

I will leave you with just a few thoughts which will summarize my discussion today. They are:

Marketing Strategy - Define the market, the distribution system, and the product. Communicate it and follow it.

People - Quality of people is the key to success.

Profitability - This must be there to support the continuing operation. Profitability means jobs!

Renewal Underwriting - This is the key to profitability.

I also concur with Mr. Peter B. Walker - it is only a myth.

MR. JAMES D. CHAPMAN: In the first part of my presentation, I would like to deal with the results for Group insurance operations in Canada during 1981. 1981 was not a very good year from a profit and loss point of view. In order to get a broader perspective on the reasons for this relatively poor performance, Mr. John Mereu, who originally had agreed to give this presentation, had the foresight to contact a number of Canadian actuaries to obtain their comments. He has forwarded their comments to me. The following then contains not only my own opinions, but also those of six of my colleagues.

There are five major items which impacted on 1981 profitability, namely:

1. Competition
2. The Financial Health of Our Policyholders
3. Expenses
4. Interaction with Government
5. Mortality

These items interact with each other. However, for ease of discussion, I will deal with them separately. My detailed comments are as follows:

1. Competition

I have some good news for Canadian actuaries who think their competitors are "crazy." Many of these "crazy" guys (gals) think that you are "crazy" too. My colleagues made comments which range from the very polite "competition in the large case field became overly intense in 1980-81," to the more blunt statement that certain competitors were acting "irresponsibly" and that they should "smarten-up." Another agreed with the idea that certain others are "following the leaders" without having a proper understanding of what they are really following. They may soon be drowning in red ink. The opinion was also expressed that certain companies seem to have opened up a market share battle, with price being used as the main weapon to increase market share.

Group insurance is sold in a free market by means of a tender system. This process has a tendency to make for unsatisfactory financial results as far as insurers are concerned. For example, if an employer or his consultant ask for a quote and seven out of eight, or 87.5 percent, of the potential insurers submit quotes which could be expected to at least break even, the lowest bidder will usually "win" the contract. Thus the tender system provides a real potential for the insurers to lose money, at least during the first year of the contract.

There are a number of areas in which we can be overly competitive with each other. The following are three such areas:

a. Premiums - There are several reasons for charging inadequate premium rates. Your underlying premium structure may be inadequate. You may give more credibility than is actually justified to a case having favorable past experience because you hope the good experience will continue forever, or perhaps you give too little credibility to a case having poor experience because you hope the extra claims have already occurred. However determined, an insufficient premium will lead to experience losses. These losses may be recoverable in future years depending on the experience rating arrangements in effect, the renewal rates which can be implemented, and how long the client stays with you.

b. Retention Levels - Large cases tend to be very sensitive to retention levels. Most companies appear to determine expense charges for large cases, at least partially,on a marginal basis. This, in itself, creates a problem for the insurer because his total expenses must be recovered from the total block of business or an expense loss will occur.

   This traditional expense recovery problem with respect to large policyholders has been compounded for some insurers by their developing some very sophisticated computer software primarily to attract large cases. The insurers developing these computer systems normally try to recover their costs over a period of years. There is the risk that the investment made in the new systems will never be fully recovered because: the insurer is unable to attract sufficient business to support the new systems; high interest rates should be used to amortize the investment made; the cost of maintaining the systems is too high, etc.

   Once you get yourself in a position of insufficient expense recovery on the large case block of business, it is very difficult to escape. The expense losses cannot be carried forward and recovered in future years. It is even difficult to avoid future losses because a significant increase in expense charges should, and probably will, drive many cases to the marketplace.

c. Experience Rating - Insurers are under extreme pressure to grant high levels of experience rating, especially for Life and LTD. The danger in granting high levels of experience rating is that too much money is returned to the policyholder having favorable experience, and there is insufficient money left over to offset cases having unfavorable experience. Of course, in theory, almost any level of

experience rating can be given to a policyholder as long as a sufficiently large risk charge is retained by the insurer. Insurers often do not make a sufficiently large risk charge for the level of experience rating being granted.

2. The Financial Health of Our Policyholders

Profits of both small and large businesses took a severe drop during 1981. Many businesses were forced to implement a hiring freeze or to lay off workers. Others went bankrupt. The situation deteriorated during the last six months of 1981. These conditions had a negative impact on Group profitability for a number of reasons.

a. The squeeze on their profits caused more policyholders to shop the market. It was harder, then, for the insurer to recover any prior losses. When the market was tested, premium rates were even more important than usual. Therefore, the new carrier was even more likely than normal to suffer losses, at least for the first year.

b. Layoffs created several difficulties. The base over which expenses are spread was reduced. Also, those with least seniority were laid off first. These tended to be the younger employees. Insurers were not able to make an upward adjustment in premium rates to recognize the older age distribution until the next anniversary.

c. Historically, high employment has contributed to poor loss-of-income experience. LTD experience can have a significant effect on profitability. A claim paying $1,000 per month requires an initial reserve of approximately $50,000. A few extra claims can ruin the bottom line rather quickly.

Most companies had poor LTD experience in 1981. Some companies commented that the situation deteriorated as 1981 progressed, or that 1982 is worse than 1981. However, considering how high unemployment levels are, it could be argued that LTD experience is not as bad as it might be.

3. Expenses

Inflation in Canada continued to be quite strong in 1981. More than one writer suggested that expenses are moving up more rapidly than expense recovery charges. Several reasons were suggested for this.

a. Expenses are moving up faster than premium income so that even if expense collections are based on a percentage of premium, the expense collections will start to fall short of the expenses incurred. This may be particularly true for Group Life insurance because decreasing mortality rates tend to hold premiums down.

b. The development of the sophisticated computer systems referred to previously.

c. As our policyholders shop the market more frequently and change carriers more often, our quotation and issue costs go up. However, the time frame for recovering first year expenses including high first year commission is narrowed.

d. A great deal of the expense problem may be historical. Interest rates tend to move up with inflation. Traditionally much of the excess investment income earned by the insurer was retained by the company as an offset to rising expenses. Interest margins on cases in the medium to large size are now rather small because of competitive pressures. It seems that most companies have not recognized the reduction in available excess investment income in their development of a proper expense recovery formula.

4. Interaction with Government

Interaction with government has always been a problem in Canada with respect to services provided to the public and with respect to taxation policies.

a. Each Provincial government provides certain Medicare and quite often certain Denticare programs to its citizens. The insurers usually pay for what the various governments do not cover. There have always been certain administrative problems associated with selling plans which wrap around a government provided program. However, it now appears that we could be heading for some serious pricing problems and hence profitability problems as well.

In the past, government programs were ever expanding. Now, however, our Provincial governments are facing large deficits and are seeking ways of reducing their expenditures. When the government reduces its Medicare/Denticare expenditures, it usually means that our claim costs will go up. Sometimes the changes are made in a way that is difficult for our premium income to keep up with the increase in claims, at least in the short run.

For example, consider the situation with respect to semiprivate hospital charges in Ontario. Prior to April of this year, the level of semiprivate charges was determined by the Provincial government and was, therefore, uniform across the Province. At the end of 1981, the Ontario government announced that it was going to cut back on its contributions to hospitals and, in return, the hospitals were given more freedom with respect to charging the public for various services. One of the freedoms granted was that each hospital could set its own semiprivate hospital rate. These changes were effective April 1st and most hospitals did not decide on their semiprivate rates until late in March. It was a little uncomfortable setting rates during the first three months of 1982, which would be competitive - yet profitable.

A more recent example is the sudden withdrawal of the British Columbia Denticare program after less than two years of operation. Approximately two weeks' notice of this withdrawal was given. It is difficult, if not impossible, to make a premium adjustment in two weeks. Depending on your legal authority according to the contract to change rates other than at the anniversary; depending on whether you are going to try to change rates even without the legal authority to do so; depending on the notice you give to policyholders before implementing a rate increase of any kind; etc. you probably dropped a few dollars as a result of the British Columbia government's action.

b. With respect to taxation, the Federal government recently changed its income tax policy concerning employer's contributions to Medical and Dental insurance plans. These contributions must now be included in the income of employees for taxation purposes. This will hold down the expansion of the Health market and perhaps contribute to a fight among insurers over market share.

5. Mortality

Offsetting the above four negative features, a number of companies reported favorable Group Life experience during 1981. Several suggestions were made as to why 1981 was so good.

a. Certainly, the year-by-year improvement in mortality is helpful (at least to the extent that you have not incorporated this improvement into your rates in advance).

b. Certain carriers are tending not to offer Waiver of Premium coverage on a significant portion of their business. By doing so, they may have avoided a high level of waiver claims which would otherwise come along with the unfavorable LTD experience.

c. Of course, 1981 may have been just a favorable fluctuation.

This brings us up to the present, at least with regard to some of the factors impacting on profitability. What seems likely in the future and, therefore, what would be an appropriate strategy? Let us review the five factors previously identified as affecting the most recent years and speculate on how those factors will impact on future years. As you will recall, the five factors are:

1. Competition
2. The Financial Health of Our Policyholders
3. Expenses
4. Interaction with Government
5. Mortality

1. Competition

Competition will intensify in the short term. Some competitors seem to be changing their strategy with respect to the Individual and Group insurance markets. They seem to believe that their Individual lines will not have favorable growth rates in the future. Many of these companies had reached this conclusion even before the Federal government's change in income tax position with regard to Income Averaging Annuities. Therefore, these companies have been and will be looking to obtain real, net of inflation,growth through the Group market.

As a result there will be new competitors, and the existing competitors will compete even harder than they have in the past. The new competitors may be particularly troublesome in the small market. They may deliberately underprice their products in order to build up a book of business and establish themselves in the marketplace. Other new competitors may underprice their products because of a lack of experience in Group pricing.

In the long run, I am a little more optimistic. Not only is the long-term prospect for growth in the Individual market down, but also the long-term potential for making a profit. The Individual Division will no longer be able to provide a large profit considerably in excess of any Group losses. Because the ongoing viability of an insurance company depends on obtaining adequate profits, there will be increased emphasis on profitability in the future for both the Individual and Group lines. This increased emphasis on profitability will cause insurers to be much less aggressive in future Group pricing.

2. The Financial Health of Our Policyholders

I am not an economist and, therefore, I am somewhat reluctant to give you any guesses about the economic future. However, given the recent sudden gyrations in inflation and unemployment, and given the long-term trend over the last 20-30 years, I would think it unwise for insurers not to at least be considering strategies appropriate to unfavorable economic conditions.

If we continue to experience unfavorable economic conditions, there will not be an expansion of the Group market because of the introduction of new benefits. In the 1960s and 1970s the size of the Group market increased with the introduction of Dental and LTD plans. The expansion of the market allowed everyone to show net of inflation growth. Without such future expansion, a fight over market share is much more likely.

3. Expenses

The problems previously identified with respect to expenses should continue, especially the squeeze on interest margins. Some companies may have an additional problem in the future. To the extent that some companies increase their Group line's size relative to the Individual line, the Group line will be allocated more of the total Company's overhead expenses.

4. Interaction with Government

Provincial governments are going to be under extreme financial stress for the foreseeable future. Therefore, one should be prepared for the further shifting of costs from the government to the private sector. One should keep one's contracts as flexible as possible with respect to being able to implement a rate change at any point in time.

5. Mortality

Whether or not the favorable mortality of 1981 will continue to be realized in future years is not at all clear. I will leave you to make your own determination in this area.

I would like to offer you the following advice with respect to managing your Group line.

1. Determine your true profit and loss for Group insurance. Determining a realistic profit and loss from your ongoing operation requires several adjustments to be made from the way you determine your solvency profit

and loss. The following, at least to the extent that you are not doing it in your solvency profit and loss, should be part of your calculations:

a. Do not include investment income arising from items such as surplus, contingency reserves, etc.

b. Remove the portion of the dividend reserve which has not yet been earned.

c. Establish a liability for deferred taxes.

d. Use a proper allocation of expenses between lines.

e. Value reserves, especially LTD reserves, on a realistic basis.

In performing the above profit and loss analysis, with the appropriate modifications to suit your own company's circumstances, you will find out how much your Group operation has really contributed to your company's bottom line performance.

2. Immunize your portfolio to protect against sudden shifts in interest rates. This is of course particularly important with respect to LTD.

3. Control expenses - of course, you still must face the dilemma of being able to provide the required computer systems, technical expertise, administrative services, etc., to effectively run the line.

4. Engage in sound initial and renewal underwriting. Of course, outbidding your competition by being sufficiently attractive with respect to premiums, financial arrangements, expenses, services provided, etc., and still having the business obtained being profitable is easier said than done.

This is my view of the recent past and the near future. No doubt I have missed a number of items that should be considered. Also, you need to weigh all the items in light of your own company's circumstances to come up with an appropriate strategy. I am sure you will find the exercise interesting and hopefully worthwhile.

MR. PHILIP BRIGGS: Under current circumstances, the subject of profitability must be a popular one in the boardrooms of most insurance companies. These are not the easiest of times and the Group business has not escaped unscathed. Nevertheless, profitability in Group can be achieved.

Through intelligent strategies and diligent follow-through, this result should be possible year in and year out. Many carriers have displayed the ability to consistently make profits, so certainly it is an attainable goal. Yet, while many companies do achieve this desirable objective, others are not so successful and their profits seem to be subject to the vicissitudes of shifting economic and competitive forces. Why one company is profitable and another is not, is obviously a rather complex question and I will try to address some of the more important considerations.

As in the case of other lines of insurance, the three important sources of profitability or loss in the Group business are: (1) underwriting gains, (2) investment gains, (3) expense gains.

While I will address each of these three sources of profitability separately, there is a common thread that distinguishes the consistently profitable company - that is one of attitude. A company that thinks in terms of profit will have a better chance of being profitable than one that thinks primarily in terms of other goals. This attitude of profit, if it is to pay off, must pervade the entire organization. Actuaries, marketing and administration people alike need to share the belief that profitability is a critical goal if this goal is to be achieved. An insurer that weighs profit heavily into its self-assessment on whether it is successful will approach its decisions from a profit viewpoint. Accordingly, it will choose its markets and the groups it underwrites more carefully, and will monitor underwriting, investment and expense performance more carefully.

1. Underwriting Gains

Underwriting gains should be an essential part of an insurance company's profitability. Underwriting gains for Life insurance have not posed much of a problem to most carriers. With annual mortality declines over the last decade in the 2-3 percent range, premium rates have typically been more than adequate to cover claims and expenses. Making money in the Medical Care area, however, has posed a more serious challenge. Many companies, in 1980 and 1981, suffered substantial Health underwriting losses. This was probably caused in part by carriers' use of inadequate medical trend factors; most carriers participated in the voluntary wage-price program in 1979 and 1980 and were tied to trend factors that became increasingly inadequate as 1980 progressed. In 1981, I suspect that most companies increased their trend factors and probably are operating today with trend factors that are appropriate.

The reasons why medical care costs continue to increase much more rapidly than the CPI are not completely understood. We are seeing the compounding effect of at least four factors: First, the basic inflationary trend which affects nearly all costs. Second, the improvements in technology that are causing a rapid improvement in the quality of diagnosis and treatment accompanied by a considerable increase in cost. Third, the very significant, but hard to quantify, impact of the shifting of medical care costs from the public to the private sector as a result of the cutbacks in Medicare and Medicaid payments. Last, the effect of a demographic shift to an older population more subject to illness.

There is one other aspect of this situation - like the statistician who drowned in the river that averaged four feet in depth, we have tended to treat medical care cost trends as events that progress evenly and uniformly throughout the year and throughout the country. The fact is that these costs vary widely in incidence by geographical area and frequently occur in spurts. The result is that we are lulled into a feeling of security by observing only a modest increase in costs for a period of time in a given locality and then are shocked to find that costs have suddenly increased much more than anticipated.

Carriers that were particularly badly hurt in the Medical Care area in 1980 and 1981 were those companies that were heavily into the smaller size Medical Care business. The larger experience rated case has the cushion provided by margins for claim fluctuations, so medical care trends in excess of expectations were often absorbed. This was not so for the smaller case where adverse medical experience went directly to the bottom line of the insurance carrier. In the smaller size case area, companies have tried to solve their problems by more careful selection of groups and by the redesign of policies. Some companies have instituted rate increases more frequently than once a year. In the larger size market, it is most important to maintain sufficient margins for claim fluctuations. Many companies use a uniform trend factor nationwide, but as previously mentioned, individual cases can exhibit trends substantially different from the averages. Accordingly, unless margins are present, a company can end up paying dividends on cases with favorable fluctuations, and lose money on those cases with unfavorable fluctuations. Also, once a case is in a deficit position, it is particularly vulnerable to making a carrier switch-over. Accordingly, a firm hand in getting the renewal increases that are requested is essential.

2. Investment Gains

In the large case market there has been an increasing emphasis on the policyholder improving his cash flow. He does this by retaining funds corresponding to the open and unreported claim reserves. Accordingly, insurance company investment funds have been decreasing. With this investment source of gain eroded, and with the rapid growth of the ASO market, it becomes ever more essential that a company strive to make money on the services that it renders.

One particularly unfortunate aspect of the last two years has been the extremely high rates of interest experienced. This has put great pressure on insurance companies to release reserves to policyholders who are hard-pressed for cash. The insurance companies were in a similar position in the Group business as they were in the Individual insurance business in that policyholders were calling for cash at a time when insurance company investments were tied up in long-term securities yielding rates which were uncompetitive with current short-term rates. I suspect that many companies suffered substantial market value losses as a result of these withdrawals.

Currently, with interest rates returning to some semblance of normalcy, we may have an opportunity to restructure the relationship of our assets to our liabilities and protect ourselves against a possible recurrence of our recent experience.

3. Expense Gains

Although the general question I am discussing is profitability, more specifically we could ask ourselves whether profitability is compatible with sales growth or more strongly put, is it compatible with a company increasing its share of the market? The answer to this question can still be answered in the affirmative. The most significant difference between the profitable and unprofitable company will not be so much in

the underwriting and investment area, but will be in how efficiently quality services can be delivered in comparison to the competition. We deal with sophisticated customers and brokers who understand value. A company that operates with an inefficient and overstaffed organization simply will not be able to pass along its costs to its customers.

With this in mind, we take our budget process very seriously. Expenditures are reviewed very carefully as to whether they are important in achieving the objectives that we set forth as a company. After the budgets are established, close monitoring and reporting is necessary in order to be certain that our expenditures are coming in at or under budget. Unit costs are reviewed to see that the trend line is acceptable. Since so many of our expenditures are claim related, we pay particular attention to this area and compare the productivity of our various claim offices. By having many claim offices spread geographically, we can learn what works best and why, and share the success formula with other claim offices.

Another element in the profitability equation is the company's dividend formula. At Metropolitan, we view this process among our most important activities. Various committees representing line and staff operations are organized to review various aspects of our dividend formula having to do with interest credits, expense charges, pool charges, and other financial matters. The budget tells us what our expenditures will be and the dividend formula is our vehicle for providing the revenues to cover our expenses. Through the dividend formula we can influence our profitability as well as our competitiveness. Careful judgments have to be reached as to the effect of various changes. For example, one could lower interest credits to raise profits but one would have to weigh the effect on our competitive position.

Strategies for Operating More Profitably in Today's Environment

A. Coping with Economic Cycles

Poor economic cycles can impact on both Medical Care, and Short and Long Term Disability coverages as regards benefit costs. In such cycles, claim rates generally deteriorate. How are some companies able to protect themselves, while others are financially overwhelmed? Certainly it is important in the large case, experience rated market to have sufficient margins for claim fluctuations. It is most desirable to encourage customers to establish claim fluctuation reserves, and this requires an attractive interest rate. Other protection in the form of retrospective premium arrangements also is desirable. In the small case market, one way to attempt to remain profitable through various economic cycles is to shoot for sizable profits in good economic conditions, and be content with smaller profits in poorer economic periods. A company makes a mistake by targeting for small consistent profits since,when the poor economic cycle occurs, it is likely that its hard-earned cumulative profits will be substantially erased.

The selection of groups to underwrite can be an important determinant of how a carrier fares in periods of poor economic cycles. Certain industries or businesses within an industry are very sensitive to temporary downturns in the economy. Accordingly, an insurer that

writes, for example, a large share of its short and long-term income replacement coverage in such a market can expect to suffer very adversely in periods of layoff and high unemployment. Also, the smaller and weaker business firm can be expected to do more price shopping in an economic downturn than would a stronger company. Accordingly, an insurer who is heavily concentrated in the small case market may be subject to a high rate of cancellation in a shaky economic climate.

Today, with business failures at an all time high, we have to be increasingly concerned with the financial condition of the customer that we insure. Accordingly, at Metropolitan we have strengthened the Investment Department's role in reviewing the financial capacity for our Group customers, particularly with regard to those situations where credit is extended in the form of retrospective premium arrangements or premium deferrals.

B. The Cost Shifting Problem

Cost shifting has added 2-3 percentage points to the annual medical trend factor for the last several years. Government, by not paying its fair share, has thrown a heavy burden on the private sector. Insurers have suffered with this problem for some time. Hopefully, the efforts of the HIAA have been successful in drawing this problem to the public's attention. The latest in the cost shifting arena (although different in nature than the typical cost shifting) is the requirement to provide primary Medical coverage for active employees age 65 through 69. Although the vast majority of employers can be expected to have a minimal number of employees in this age bracket, Metropolitan does have some groups where the percentage of employees in this age range is enough to add materially to the total cost of the medical program. In addition to the extra costs created by cost shifting, we have the problem regarding the uncertainty as to what the next government action will be. It is difficult enough to try to project medical care cost trends without the additional imponderable of what the government will do next in trying to reduce its own budgetary problems. The most recent proposal to have the Federal government use a "diagnosis related groups" approach to the reimbursement of hospitals may cause additional problems for the insurance industry unless it is applied to all patients.

C. Organizational Structure

At Metropolitan we have decentralized many of our Group functions to locations outside our Home Office. The Group Officer in charge of each decentralized operation has been given a substantial amount of responsibility for sales, administration, and financial results. We view our decentralization as a success in that we are able to provide better, more efficient service to our customers. From an organizational point of view, we feel it is important to place both the sales and financial results with the same individual. Along a similar approach, we have appointed product managers for our small case market and Credit Insurance market. These individuals have significant overall sales, service and financial responsibility. Control and monitoring of our various profit centers is performed at the Corporate level. Also, company-wide operating practices and philosophy are established at the Corporate level and are followed by the various profit centers.

With a decentralized operation, it is extremely important to have a comprehensive management reporting system. The proper amount of detail must be supplied to each manager in the decentralized environment so that he can discharge his responsibilities effectively. Also, the Corporate Headquarters requires comprehensive reports that indicate on a current basis the profitability of the decentralized operation. Data should be available with regard to sales results, underwriting results, and expenditures.

D. Marketing Strategies - Product Design and Pricing

A company has to make the important decisions as to what products it will market, what type of groups it will sell, and in what size market it will operate. If the right decisions are made, profitability will be enhanced and the organization will be more effective. The wrong decisions, of course, can lead to a drag on the company's manpower and profitability. At Metropolitan, marketing, product design, and pricing are coordinated; marketing people confer with pricing personnel in the design of the product. The individuals responsible for pricing, in turn, must get input from marketing as to the commissions and other sales-related expenses so it can be factored into the premium structure properly.

The decision to enter a particular market is often not limited to the question of profitability. Other considerations also impact such as the following:

a) Does our company presently have the expertise to sell and administer the product?

b) What are the start-up costs? Will the costs be too much of a drain on our financial and human resources?

c) Will selling this particular product help sell other products in the Metropolitan portfolio?

d) Will the sale of this product significantly increase the income of our Group sales force?

There is a new factor in the company's Group profitability - that is the so-called Stopgap tax law which became effective retroactively for 1982 and will be in effect at least through 1983. For many companies, the Stopgap law represents a major change with regard to the impact of Federal income taxation on our business.

In conclusion, attaining and retaining profitability in the Group business is dependent on the same basic attributes that one needs in running any business: careful selection of market, effective marketing, tight budget control, intelligent pricing, and quality of product. It is a lot easier to describe this policy than to carry it out.

One more point: Group is no longer a minor part of an insurance company's operations. In most instances, it is the most rapidly growing part of the company. Therefore, it is essential that it be profitable.

MR. JONATHAN ROSENBLITH: I ask Mr. Briggs or anybody in the audience, what their experience with ASOs of any sort, or CSOs, has been over the last year? Last year at the Annual Meeting a lot of big companies had had some problems with them. The Marketing Department, where I am working now would love to have us write some of those and I am a little cautious about that.

MR. PHILIP BRIGGS: ASO has been a problem from the beginning because we were brought up in an environment where we expected to make some profits on risk charges and on interest margins. We felt reasonably fortunate if we could break even in our expenses. That is really no way to run a business when your only business is administering, if that is what you are doing. Speaking for Metropolitan, we have had to adjust our sights. ASO business has to be a profitable business in its own right. It is not an easy business in which to be profitable, and we have changed our practices over the last two or three years to the point where we think we can make a profit out of it.

MR. PAUL R. FLEISCHACKER: A related question to the ASO is what has been the experience in the Stop-Loss marketplace? The losses have been very heavy over the last 12-18 months and I have heard a lot of comments regarding companies considering getting into this. I would like the reaction of the Panel.

MR. RONALD L. WOBBEKING: We were in the Stop-Loss area fairly heavily and I would have to admit that our experience has been marginal. It has been improving in the last year and a half, but up until that point it was not good.

MR. EDWARD G. WENDT: Mr. Chapman comments on the unfavorable experience in Canada with respect to LTD in 1981 and 1982. I am frank to admit I have not heard much talk about how unprofitable LTD has been in the United States during this period, and I would appreciate any comments about that aspect of our business and its profitability during that period.

MR. PHILIP BRIGGS: I am not aware of a very deteriorating situation. We have some slightly worse experience, but not a much worse situation.

MR. WILLIAM G. POORTVLIET: We have seen some worsening of experience but it has been a rather modest worsening, as far as our own business is concerned. In speaking to other companies, I have heard one or two say that they were surprised that the experience has not worsened more than it has.

MR. PHILIP BRIGGS: It is not a disaster, if that is what you were asking. We do not see a disaster.

MR. EDWARD G. WENDT: No. I am wondering if we have something to anticipate in the future, here. It is not unusual to see worsening experience follow a high period of unemployment. We are in such a period now. Could you comment on what happened in Canada to stimulate this poor experience in 1981?

MR. JAMES D. CHAPMAN: I would assume that it is the economic situation that has caused it. I am not very familiar with the United States situation, but your Social Security probably picks up a bigger share of loss of income for more poorly paid employees than in Canada. We may be impacted on the lower

end of the economic scale in Canada more than the United States. That may be a reason why the situation is worse in Canada than in the United States.

MR. RONALD L. WOBBEKING: We do not have a very big book of business. Most of our business is medium-term, and our experience the last two years has been much better than it was before then.

MR. LLOYD G. ROLLERSON: Our Canadian LTD experience has been very bad in the last two years, but our United States experience has continued to be very, very good. The best explanation that we could come up with is that much of our Canadian business is on large cases, often in the resource industries (e.g., the lumber industry in British Columbia, which is very depressed, etc.), whereas in the United States a pretty high proportion of the business is white collar business on smaller firms,and that has held up very well.

MR. SANFORD B. HERMAN: One area that was touched on very briefly by Mr. Briggs was the Stop-Gap legislation. This is going to have a much greater affect on mutual companies than on stock companies. The mutual companies have developed tremendous assets over the years from the Ordinary lines, creating investment income and dividends to policyholders which were not deductible under the old law and had adverse effects in the allocation of Federal income tax to the Group lines. In the case of my own company, our bottom line for 1981 for Group would have been a break-even situation before Federal income taxes, but because of the peculiarities of the 1959 Act, we actually showed a $6 million loss, strictly from investment income that was not attributable to any kind of profit at all.

MR. GEOFFREY L. KISCHUK: I tend to agree with Mr. Briggs that some of the stock companies seem to do a little better. One of the reasons, though, seems to be that they have built up stabilization reserves over the years that seem to be depleted pretty much from a lot of the things that we are seeing. Nobody is going to be able to continue to be profitable in the Health line as long as the competition is where it is. Our Life experience is not unusual. We make money in Life not really on our actual claims, but on our pooling. We have more deficits than we do deficit recoups. On the large size cases, there is a tendency toward Self-Funding; TPAs are gearing up so they can handle even the largest policyholders; the large policyholders also pay their own claims. Small companies, if they are in Group insurance, are in the small Group Health area, so it is very competitive at the lower levels. There is a national broker who has a pilot project in Milwaukee. They are going to be doing everything - underwriting, claims paying, etc. All they want is some insurer to take the Health risk. That is going to introduce even more competition.

MR. ANTHONY J. HOUGHTON: I would like to make one comment with regard to the ASO type of coverage. We see an enormous number of the larger groups moving to some type of risk transfer where they are asking some insurance company or Blue Cross-Blue Shield organization to perform a very limited amount of services for the very lowest possible administrative charge. There is a trap that some of the insurance companies or Blue Cross-Blue Shield organizations we have dealt with have fallen into because the policyholder asked only for certain claim/administrative services to the exclusion of other services. The companies assumed that the expenses related to these other services have completely disappeared, when in fact

they have not. They are still incurring some expenses in certain lines, such as overhead, certain marketing expenses which may not be given directly to that policyholder, or to things related to auditing of hospitals, etc. Somehow they have minimized the expenses they are building into the administrative service contracts to some of these policyholders and have not transferred the actual expenses to the charges they are making to other policyholders. In addition, many of these policyholders, while they have said they do not want these other services, in effect will come back to the company and say, "They changed the law on the 65 to 69, what do we do?" They will ask for legal work; they will ask for policyholder contract work; they will ask for actuarial work, financial analysis, values of benefits, etc. Frequently these Blue Cross-Blue Shield plans or insurance companies will, in effect, provide much of these other services at no charge. The other side of this trap is that frequently some of the administrators who have sold this idea to policyholders have not told them that in cases where the insurance companies fail to give these services at no charge, they may have to go to a third party, such as a lawyer, an actuary, or an accountant and pay these people on an hourly rate to provide them with the services they used to obtain as part of their retentions. It is, therefore, very important that these companies communicate exactly what they are charging for and what services they are providing, to make sure that everybody protects their own interests.

MR. PHILIP BRIGGS: I agree. That is what I had in mind when I talked about ASO business before. As we unbundle our services and provide risk-taking, investment services, administrative services, and expert advice, etc., we have to go back to basics in terms of how we price each of these. In the past, when we provided a package of services to an employer, it did not matter too much whether we were exact on one service or another, because what was wrong in one place was offset in some other place. When you are unbundling, you have to be right on each piece. We are learning to be much more sophisticated in our pricing. Our financial viability depends on it. Especially, as you say, the trend that you described is continuing. We are going to see more and more of this and we should learn how to price it properly.

MR. PAUL R. FLEISCHACKER: Often the employer focuses on having a very low retention cost and does not really focus on the total cost of his program. As a result, he loses sight of the fact that with insurance companies that have set up good cost containment programs within their claims administrative systems - that the additional cost for that claim service will more than be offset by the savings in claim dollars. For example, a report that summarizes some of the effects of cost containment activities states the following: on claims review and control, Smith Corona Corporation has 22,000 employees and realized $375,000 in savings in the first year; Rockwell International with 100,000 employees realized $7 million in savings over eight years. On the Coordination of Benefits provision, the HIAA study, a multicompany study, indicated a 3.8 percent savings on total benefit payments to claimants. The Borden Corporation realized $2.1 million savings, or 14 percent of total premium. On auditing of bills and records,the Kennicott Corporation achieved 12 percent hospital cost savings, 11 percent decrease in inpatient surgery, 22 percent decrease in use of assistant surgeons,and a 4 percent decrease in inpatient days.

MR. DONALD M. PETERSON: A couple of other traps our customers, and to some extent the insurers, were falling into are in the ASO and the Stop-Loss areas. The first might be one which applied more directly to the buyer. This is where the consultant comes in and says, "Listen, you are paying $120 a month per employee right now for your Health benefit package. I can save you 30 percent next year." The underlying fact that is not brought out is that the claim reserves are being run out by the insurance carrier on the current year's risk and the claim reserve liability is being shifted to the employer, sometimes unbeknownst to him, in the future. This savings disappears after one year. When this is brought to the attention of many of our customers,they then have a different potential outlook as far as administrative services and self-insurance is concerned. Secondly, with respect to the administrative services with a Stop-Loss, perhaps we are running into an area where we are not aware of what risks are actually involved. When we tried to "stop-loss" a case 20 or 25 percent beyond expected claims in the past, we felt pretty safe. The likelihood of a case that we were somewhat familiar with generating experience out that far was rather small and our risk charges were commensurately small. Nowadays, we are in an area where the inflation rates are approaching that 20 or 25 percent fluctuation rate and, more importantly, we are not paying the claims. Third party administrators are paying the claims and they are often compensated on a percentage of the claims processed. The claim cost controls that our Claim Departments were exercising in past years may not be existent right now. We are sitting on top of a time bomb as far as the aggregate Stop-Loss risk is concerned. We are well advised to stay on top of that before we are embarrassed a year or two down the road.

MR. MORTON B. HESS: What is the general feeling on the insurance companies' liability for absorbing administrative error in the claims administration of a contract, that is, in overpayment of claims or poor coordination of benefits, increasing the cost of the experience under a particular contract? How much of that should be charged to the contract and how much should be absorbed by the company?

MR. PHILIP BRIGGS: The whole question of what is the proper responsibility of an insurance carrier in administering claims is a delicate question. Historically, insurance companies employed their best efforts to pay claims properly. Unless there was a clear irresponsibility or fraud, in general the claims that were paid by the carrier were charged against that contract. That is the way risk charges have been calculated and that has been the basic assumption of the business. Whether this is going to be acceptable to all large employers in the long run, I do not know. In an ASO situation where the employer is completely footing the bill and the administrator is only acting as his agent, there is really no recourse. In that instance, you can fire the agent and get another one if you do not like the way he administers the claims, but I do not know what other recall you have on the administrator. If the insurance company had to absorb each and every one of the extra payments it made, it would be an intolerable situation.

MR. RONALD L. WOBBEKING: Well, I would just follow up and say that basically it is a legal question, but even if it came down to the companies having to absorb those costs, they are going to build it right back into their expenses. One way or another it is going to come back.

MR. MORTON B. HESS: Is there a concurrence that under ASO there will be absolutely no responsibility for claim administration error? Is that the generally accepted legal theory?

MR. PHILIP BRIGGS: I for one am not a lawyer, so I really cannot answer that question, but in my experience, at least up until now, I have not heard of a situation where it has been otherwise.

MR. ANTHONY J. HOUCHTON: I would like to mention our specific case. The State of Illinois put out their State Employees' Medical Plan for both an insured and an ASO quotation. On the ASO they had three different carriers make a proposal. One was the Chicago Blue Cross-Blue Shield, another was CNA, and the other was a small corporation that was a third-party administrator, which, of course, if they made any big error, would not have had any monies available to make good on them. The quotation asked, "What will happen if there are errors made?" This third-party administrator said they would do their best to recover from the people for whom they made the duplicate payments, or whatever. They said in the past they had recovered about 95 percent of all monies paid in error. The CNA said substantially the same thing. If there were any errors, they would do their best to recover them, but if they couldn't, they would not take responsibility. Chicago Blue Cross-Blue Shield said they would take responsibility for any errors that were their fault, but if their errors were made because the policyholder had not given them proper information about when people terminated or any other items, they would not have responsibility. If you do not ask the question as a policyholder, anyone on ASO will just say it is a question of best faith effort.

MR. PHILIP BRIGGS: Those of the companies represented here who are in the Medicare business will know that the Federal government, in having insurance companies administer Medicare, have what they feel is an allowable error rate. Within that allowable error rate, there is no real question raised by Medicare as to how things are going. Of course Medicare very carefully monitors the error rate with regard to claim administration. If the error rate exceeds that guideline, then they raise questions with the administrator as to what they are doing. They increase their surveillance until the situation is resolved. In any case, that is one area where we have some precedent with regard to error rate.

MR. JEFFREY D. MILLER: Mr. Wobbeking, you sounded as though your company makes use of third-party administrators quite extensively. I was wondering if you could share with us some of your standards for choosing those administrators and some of your methods for auditing them and controlling them.

MR. RONALD L. WOBBEKING: We obtain three questionnaires prior to approval. One is a marketing questionnaire, one is administrative, and the other is a claims questionnaire. Each of these three is dealt with independently in our company and any one of the three can veto the approval of a third-party administrator. They cannot give us any business and cannot quote on our business until this process has been completed. After approval, we audit at least once a year, and we also audit every aggregate claim we ever had. We go back and audit the whole account. We audit fairly extensively and, if we get a little nervous, we will also audit more frequently.

MR. RICHARD W. CARNER: I have a further question about Croup LTD experience. There has been much discussion about the Social Security Administration changing their standards, both for making initial disability awards and in their CDI program, going back to people who have been on the disability rolls for some time and redetermining whether or not they qualify. In our experience during the last year we have had a reserve increase of about $3 million on a total of about $170 million from individuals who have had Social Security benefits terminated and on whom we have to then pick up that additional monthly income. Is there a concern on the part of other companies or anyone on the Panel, that the changes in standards are going to significantly impact the LTD experience from now on?

MS. KATHLEEN BURT: Unfortunately, we do not have information on deductible benefits on our computer, so it is difficult for us to extract the information. Our claims examiners have been telling us that it is taking longer for people to get Social Security benefits and that more people recently have been denied Social Security benefits. We are in the process now of extracting and compiling this information manually. One study we were able to complete by computer tracks the number of claimants receiving the gross benefit. That has increased quite a bit over the past several years.