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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. ALAN M. THALER: I would like to draw attention to the fact that our topic is not merely "small group programs" but rather the topic is "operating a successful small group program". You may well question the significance of this distinction. After all, who would be interested in operating a small group program if it were other than profitable and successful? The fact is that insurance companies over the last half dozen years have been rather schizophrenic as to whether small group programs can or cannot be operated on a successful basis.

Many will recall that in 1975 and 1976, following the end of the wage and price freeze that had been imposed by the Nixon administration, there were a series of sharp escalations in the cost and utilization of medical care which took many companies, not only in the small group business but also in the large group business, by surprise. With respect to the small group business, there were some notable repercussions resulting from the severe losses of Old Republic. Those losses resulted in an order from the Illinois Insurance Department to Old Republic to desist from doing that business. It also may be recalled that Old Security and Loyal Protective sustained losses in small group that put them out of business.

In 1980 and 1981, we had a somewhat similar unanticipated upsurge in claim experience following, not a wage and price freeze, but rather the voluntary wage and price stabilization program placed in effect by the Carter administration. When it became apparent that this voluntary program would be dropped, the voluntary restraints that were imposed in 1978 and 1979 were gradually forgotten; and in 1981, we saw an especially dramatic upsurge in the cost of medical care, which again was in many instances unanticipated by insurers.

One might ask, how can memory in the industry be so short-lived that such a recent lesson as was experienced six years before had to be relearned, but the fact is memories are short. Also, because of the voluntary aspect, the situation was not entirely a parallel one. Furthermore, there is no doubt that the shifting of medical cost from the public to the private sector which has been going on for many years also has intensified in the last few years.

I would like to sound a positive note for this discussion by saying that I firmly believe that small group business can be successfully operated, but not by continuing to follow practices that have given rise to troubles in years past. The fact that old systems no longer work is best illustrated by considering what has happened to major medical premium rates since 1979. In that year insurers were charging rates based on an assumed upward annual trend of about 12%. In 1981, the annualized trend rate actually experienced rose to more that 20%, and for some insurers to more than 30%. Clearly, in such a fast changing environment, the slow reacting systems that have been typical of the operations of most insurance companies in this business are no longer effective. Also, when the cost of coverage gets as high as it now is, the price awareness of consumers and agents is intensified, and greater protection is needed to guard against adverse selection than has been necessary in the past.

Following the trauma in terms of adverse experience that shook the industry in 1975 and 1976, many companies either withdrew from the small group business or deferred consideration of the idea of entering it. This was followed by a more reasonable attitude during the years of 1977 to 1980 when companies again saw small group business as attractive both for their agents and for its profit potential. However, now once again, following the losses of 1981, confidence has been shaken. In fact, the chief executive officer of one company very active in small group has been reported as saying that there is no way a company can any longer operate profitably in this business.

The most compelling reason I can offer in support of my optimistic position is that in spite of the sharply rising cost of medical care, individuals cannot afford to be without reasonably adequate medical care protection. The fact that the cost of medical care is a deductible business expense in effect cuts the true cost to the employee in half when the employer buys the plan with before tax dollars. These reasons provide the assurance that as long as present conditions continue, small businesses will purchase this essential coverage regardless of the price tag. Thus, as costs rise, small employers and individuals do not have the choice of dropping their medical expense coverage. They only have the choice to select among insurers. From the insurance company standpoint, the problem reduces to one of improved management. Let me cite a few examples of opportunities for improvement:

- Large rate increases imposed at any one time invite comparison shopping and encourage customers to move to another carrier. In spite of this danger, many companies have made it a practice to guarantee premium rates for a year at a time instead of making small rate adjustments at much more frequent intervals on a basis that closely follows current trends.

- A surprising number of companies have failed to make use of the most modern on-line computer systems which enable them to pinpoint and correct problem areas quickly.

- In many cases, insurance companies have not worked nearly hard enough at paying only bona fide claims. For example, often both a husband and wife are employed and each is covered by his or her employer's plan. But the insurance companies often fail to coordinate payment of benefits with the other insurer.

- Also, on small group coverage, there is no question that the opportunities for selection against the company are little different than those that are encountered in writing individual health insurance; yet many companies exercise little or no underwriting care either at the field or home office level.

Our panel today is going to present some specific answers on how to address the problems that I have briefly sketched. Let me introduce our panelists. Irwin Stricker is from Guardian Life, a company with a long reputation of operating a high quality and very successful small group business. John McBride is from Massachusetts Mutual Life, a relative newcomer to the small group business and a company that is encouraged by what they have found so far. Steven Cooper of Security Benefit Life should balance out the panel since he is from a company that apparently shares the opinion of the chief executive officer to whom I referred earlier, by reaching the conclusion that it may not be possible to continue to make profits in this business.

IRWIN J. STRICKER: I must preface my remarks with a brief comment about the Guardian's philosophy toward the small group market. We are in that market because we want to be. We are successful in it - in most years, anyway - because we pay attention to it. Because of the independence granted us, and this is the result of a farsighted position consistently taken by our senior management, we do not write it as an accommodation to our individual life field force. This has permitted us to establish life requirements and an average amount of life volume per employee far greater than that of most companies. The resultant life experience has been the source of additional margins to our portfolio. We try to keep the rules simple. If they occasionally get complex, as in the case of the medical riders I will mention later, it is because we are determined to underwrite a new case profitably. I think our viewpoint will become apparent as I briefly explain our procedures, beginning with our techniques for monitoring financial results.

While the key elements of success or failure are similar for small and large groups, the techniques for monitoring financial results vary somewhat. Because of special characteristics of small groups, we believe it is important to focus on their anticipated experience patterns. In reviewing our experience for small groups, by which we at the Guardian mean fewer than ten lives but at least one, we prepare and then examine a series of reports. Each is broken down by the geographic areas served by our regional group sales offices. Our greatest concern is with the experience of each product within each region. We evaluate our figures on a select

basis. It would not make much sense to base rating actions on first year experience of business that has been underwritten. It is helpful to evaluate the extent of the select period. We have learned that due to employee turnover, and our subsequent underwriting of new employees, the effects of selection never quite wear off. We are also concerned with experience by size of case. These reports allow us to analyze expenses rationally. And, because our rules vary by number of lives, they permit us to examine differences in experience between underwritten and non-underwritten cases.

We also analyze bottom line results, breaking out our small group business separately. We determine a profit and loss statement for each sales office. These gains and losses, when combined with those of groups of ten or more lives, are translated into adjustments in incentive compensation. Those figures, and the resulting bonus adjustments, have a considerable psychological, and occasionally sobering, effect. They also assure that our salesmen maintain a high level of concern about profitability. As an interesting side effect, the dissemination of the results puts us in the position of having to explain our rating actions in light of earnings. I suppose there is nothing wrong with us being held accountable.

Let me go on to the use of individual underwriting and substandard ratings. We underwrite all employees for groups with fewer than ten employees. For groups with fewer than six employees, we underwrite all family members, as we do for groups of six to nine employees if there is a family-related situation. We give substandard ratings to both life and health insurance. Life ratings take the form of adding on years, and health ratings are expressed as a percentage increase in the rate. In addition, we "rider out" specific medical conditions. We do not cover them as long as the policy is in-force unless, upon subsequent submission of proof of insurability, the rider is removed.

The third and last topic I will cover this morning is concerned with problems that occupy much thought at the Guardian and, I suspect, other companies as well; rate guarantees and frequency of rate adjustments. We have recently amended our multiple employer trust to give us the right to increase rates on any premium due date. Previously our contract prohibited us from raising rates more frequently than once in any twelve month period. We will make no immediate move, but intend to review the question of off-anniversary increases frequently. And we plan, at least for the moment, to continue to guarantee the rates for new business for at least one year.

To sum up, I believe a small group operation can be profitably managed. Among the key elements for success are a properly and profitably motivated field force, careful selection of risk, and continuous monitoring of benefits and expenses.

JOHN F. MCBRIDE: Mass Mutual entered the small group business in the fall of 1979, and my remarks this morning are based on a review of our experience since that time. First, because of its obvious importance, I would like to discuss our techniques for monitoring financial results. We employ two main approaches. First, we compile aggregate premium, claims and expense information that is segregated by coverage. Using this, we determine incurred loss ratio estimates each month, and we prepare financial statements for reporting purposes. Secondly, we monitor our major medical results at the employer level by the use of the claim lag patterns developed

in the aggregate and an expected loss ratio determined from our expense studies on total small group business. An expected paid claim figure is then computed from the monthly premiums on each case and is compared to actual paid claims on that case. The case level statistics are determined monthly and reports are generated summing the case level information in various ways. For example, we look at the sum of the major medical experience for all cases in each three-digit zip code in the country. These results must be used with caution because of statistical fluctuation and the impact of large claims, but we find them quite useful. Other reports look at experience by industry, case size at issue, plan, and age of case.

This second approach leads into the role of the agent and our sales management. The primary agent is identified at the case level, and the major medical experience is sorted by agent and summarized by agency. Each general agent then receives a copy of the report showing the experience on each of his agents. They are encouraged to consult with agents who have poor results in order to improve the field underwriting where possible. Naturally, this data is helpful in discussing the need for rate changes in agencies where experience deviates from overall results. In addition to involving the general agents in monitoring financial results, we also encourage them to promote training in their agency through participation in a specialist program. This involves the designation of someone in the agency as a focal point for training of new agents in selling and administration of our small group product. This approach is still in its early stages, but we are optimistic about it, particularly due to its success for some of our other product lines, such as disability income.

The last topic I wish to comment on is trends in coverage. As I said, we began our small group line late in 1979. In July of 1980, we made several additional coverages available, and they have attracted many buyers, indicating a desire among small employers for diverse health plans. The options introduced in 1980 were dental, maternity, and prescription drugs; and to date, we have not suffered financially due to their availability. Additionally, in 1981, we added a $250 deductible major medical plan to our portfolio. This has sold well and has been used extensively as an aid in preserving existing clients who had purchased richer plans, but who did not want to greatly weaken their plans at renewal when a significant rate increase was required.

MR. STEVE L. COOPER: A great game is being played in the United States right now - it is called "perfect care", and it has very simple rules - provide the best medical care possible to everybody without regard to cost. The players are predominately doctors and patients. It is frequently played in hospitals, but not always. There are not too many left out of the game - except the payers and these are few - insurance companies, employers and the federal government. Given large budgets and direction, teams of scientists have sent men to the moon, probed our planetary system and developed a vehicle for leaving the earth's atmosphere and returning. Other scientists, equally dedicated and at least equally funded, though not necessarily from the same sources, are working on increasing our ability to keep humans alive and perhaps functioning. They put no constraints on their technology - no limit on the value of being able to extend a human life.

One of the payers in this set-up, Uncle Sam, is not interested in paying so much - and so the other major payer picks up more of the bills. And inflation, technology, cost shift, human expectations and social and legal mores combine to make our task, as the payer without any power, a challenging one, but not, of late, a rewarding one in financial terms.

At my company most of our health coverage is on small groups; most of it is comprehensive major medical, and there is very little that is not covered or that has benefits limited in any way. We have been heavily involved in the business since the late 60's. Our experience in 1981, as compared to 1980, indicated that the underlying claims cost increase was about 24%. This is not, however, due to the average appendectomy costing 24% more or a day in the hospital costing 24% more. One of the major concerns and causes was an increase in the number of claims above $25,000, which increased 50% in one year. In conversations with other companies I have found we are not the only ones to see the increase in the number of jumbo claims. Incidentally, if health costs increase at 24% per year, and if one assumes wages increase at 10% per year, health coverage will consume about 20% of payroll in ten years.

How does a company protect itself?

One way is with the ability to change rates frequently on all its health business. In the multiple employer trust (MET) business a few years ago it was not uncommon for rates to be changed annually for new sales, with a twelve month rate guarantee on all in-force cases. You could have the extreme case of a group getting a rate 23 months after that rate was set.

More frequent adjustments of rates for new sales have been common lately, perhaps coming as often as quarterly. In the small group area, rates have often been adjusted monthly for new sales. More and more companies are moving to eliminate the rate guarantees for any period making it possible to adjust rates on any premium due date for any in-force case. This is a practice our company has used in the MET area for a long time, so that rate increases occur as frequently as necessary and apply immediately to all business in force. It is also necessary to watch experience by geographical area and adjust cases by changing area ratings frequently. Rate adjustments will not, by themselves, solve the problems of adverse selection and bad experience, but should help a company keep up with basic increases in claims costs.

A company must also protect itself with benefit design and contractual provisions. The obvious provisions deal with defining the risk -

1. The chance of loss should be prospective - through pre-existing condition exclusions. If you are using a trust you must take care in establishing the trust situs.

2. An expense should be covered only once, at least by group coverage, through coordination of benefits provisions.

3. The loss should be only partially insured through coinsurance and deductibles, so that the seeker of care has some financial interest in controlling cost.

4. The loss should be insurable or medically necessary, through exclusions for cosmetic surgery and experimental treatment.

5. Also, many feel we should be encouraging second opinions for non-emergency surgery and encouraging the use of the most economic care by paying for outpatient treatment and treatment by paramedics.

6. We can put an overall cap on the amount of money which will be paid out for a given individual by using outside limits.

7. In the small group area other provisions are also necessary such as:

   - underwriting and excluding lives and/or specific medical conditions;

   - making coverage non-occupational since several states allow employers to opt out of worker's compensation;

   - providing a medicare supplement above age 65 instead of full coverage integrated with Social Security;

   - keeping options to a minimum and setting careful rules about switching between these options.

Even these protective clauses do not really address the problem of the "perfect care game". Deductibles are too low, and if they are raised significantly, one finds the insurance is being used for excess coverage over a self-insured plan. Coinsurance features top out at about $1,000 out-of-pocket, and then the insurer is totally on the risk. Maximum limits are high enough to challenge even medical ingenuity, with $1 million maximums the apparent norm and with some plans offering unlimited benefits. Coverage definitions get ignored by insurance departments and courts when they differ from the public's "expectations". Another, more innovative, approach calls for returning unused deductibles to employees in whole or part - sometimes referred to as a stay-well concept. This attacks the lower end of the frequency curve of medical costs but does not get at the problem of a shifting curve created by new technology.

I submit to you an observation which totally ignores today's marketplace. If you want to protect yourselves and return to a saner situation, look at today's typical dental policy and what it provides.

1. preventative care - primarily check-ups - frequently 100% covered

2. scheduled benefits

3. deductibles of a significant amount relative to the typical cost of dental procedures

4. coinsurance of a meaningful amount

5. allowance for elective procedures but only at an extra cost to both employers and employees with very high coinsurance

Once upon a time our health contracts looked very similar to today's dental coverage - good experience and competition have changed that - and even though we are the payers and not the players in the game of "perfect care" - we created the game and set the rules. I am thinking of becoming a dentist - since I am sure that good experience and competition will be evolving that coverage as well.

MR. DREW S. DAVIDOFF: What has been the reaction of the small groups when you switch from telling them your rates are guaranteed for twelve months to telling them you can change the rates at any time?

MR. STRICKER: We recently amended our trust to give us the right to increase rates on any premium due date, but we have not done so yet. It is not our intent to notify employer units of this until the time when we actually raise rates more frequently than once every twelve months. The situation is one of selecting among several alternatives, none of which are particularly desirable, and raising rates more frequently than once a year may be the best alternative.

MR. COOPER: I am not sure what the reaction to the switch would be since we started out with the right to change rates at any time and have used it frequently. In practice we were giving a ninety day guarantee. The problem was more with our field force than it was with the ultimate buyer.

MR. THALER: A number of our clients have been using rerate practices more frequently than once a year, typically every six months. There has been a movement to every three months, and as Steve pointed out, the objections come more from the field than the consumer. If the consumer is educated, he will accept it; and a small increase, rather than a large one, is an important factor in making the business stick.

MR. VINCENT S. ZINK: I have a question for Mr. Stricker about the range of the bonus arrangement on a profit and loss operation to the agency force. If you are paying an agent X% as compensation, how much of an increase can he get on a profit sharing arrangement for a profitable group?

MR. STRICKER: The adjustments in incentive compensation are not by group. For each office we develop an adjusted profit which includes a modification of the life experience to eliminate claim distortions in any particular year. We then work off of a table which can either increase or decrease the amount of compensation that would have otherwise been payable. The adjustments have ranged from as much as an additional 20% to a decline of 30%.

MR. WILLIAM SONNLEITNER: I have several questions for Mr. Stricker. First, you mentioned that you require a higher than average life amount for your small groups. What is that amount? Secondly, you analyze your experience by select and ultimate periods. What is the level of your ultimate experience compared to that in the first or second year? Finally, what is the difference in your experience between groups of five lives or less and groups of six to nine lives?

MR. STRICKER: For groups of two or more lives we require a minimum average life volume of $75,000. I vaguely alluded to the fact that we write one life groups. We have more restrictive rules on these groups, and we require $100,000 or $150,000 of life insurance volume. The difference between our select and ultimate experience is about 20% to 25%. As I mentioned, since we underwrite new employees, even policies issued eight or nine years ago will still have fair numbers of employees throughout different points in the select period. On your final question, we oddly enough find that our experience on six to nine life groups is not very different from smaller groups. The only difference in the underwriting there is on dependents. But even on dependents, although it is slightly higher, it is not too dissimilar.

MR. THALER: Could you comment on the extent to which you underwrite life insurance versus medical on those groups?

MR. STRICKER: Our underwriting of life insurance starts with at least the completion of a health statement. Depending on the amount of insurance, we require MIB's, APS's and full medicals. For one life groups, I think everything is subject to evidence of insurability. We have a fair amount of medical underwriting and a fair amount of excess life insurance on our less than ten life groups.

MR. EARL L. HOFFMAN: We currently have guaranteed issue at six lives, and our experience on recently issued groups shows that the paid loss ratios were considerably higher for groups right above the guaranteed issue limit. We had about a 40% paid loss ratio on groups of five or less lives and on groups of ten or more lives. But in the six to nine life category our paid loss ratio was 70%. For that reason we are going to a guaranteed issue limit of nine lives starting this summer.

We also feel that we need more information on guaranteed issue cases, especially transfer business. Our trust is sitused in Minnesota which has tough requirements on transfer business, including "no loss - no gain" treatment. We cannot have an actively-at-work requirement. Unfortunately, it is almost impossible to get experience from the prior carrier since the groups are too small for most carriers to bother with supplying information to the succeeding carrier. We are attempting to deal with this problem by requiring a change of insurer form on transfer business. Among other things, we ask why the insurance is being switched, and we ask the employer to provide information about any employees or dependents who might have potentially large claims in the near future.

Another issue we have been trying to deal with is what size case should we stop writing in our small group trust. Currently we stop at thirty lives, but there has been pressure from our agency department to go to fifty lives. When you go above 20 to 25 lives, the question arises of whether you should experience rate these groups or demand experience from the prior carrier.

MR. THALER: We have observed a trend to move the limit up to twenty-four lives and, in some cases, fifty lives, with very little experience rating within that size range.

Contrary to some of the comments that have been made, we have fairly consistently observed a marked differential in experience at whatever size limit you break off underwriting. If you are currently setting that break at six lives, when you move it to nine lives, you will get the break in experience at that point. All you are doing is shifting the problem from one position to another. There is another option you might want to consider in reference to your Minnesota trust. You might want to explore changing the situs of your trust by forming a new trust in a more favorable state. Having to give up your pre-existing condition provision is a problem that is going to be devastating for you if you do not deal with it.

MR. DAVID L. E. BATES: There have been comments concerning the significant amount of excess coverage on this business, and another comment indicating there are considerably high coverage requirements for issue. There is an interaction between underwriting and coverage limits, and I would like to know what coverage limits there are. How is renewal underwriting done? For instance, if the life coverage is a times salary plan, is there extensive medical underwriting at renewal as salaries increase? At what stage does excess life kick in? How do the minimum coverage requirements affect all of this?

MR. STRICKER: Excess life kicks in for us at over $50,000 of volume. Most of our groups under ten lives are written on a class arrangement rather than as a function of salary. We would require additional underwriting if it were written on a function of salary basis.

MR. BATES: Mr. Stricker, you indicated life amounts of $100,000 on one life and $75,000 on two lives. Are these minimum issue requirements?

MR. STRICKER: Yes, but we will always have medical underwriting on amounts in excess of $50,000.

MR. THALER: You should understand that each life is underwritten, and there is a right to get evidence on any increase in the amount of insurance.

MR. RICHARD J. ESTELL: We have just started in the small group business this year and we have picked Missouri to file our trust. We have taken the stance, thus far, of filing for informational purposes in all states where we intend to write. Quite a few states have required changes in the contract even though the trust is not in their state. Is this a common problem, or do you ignore other state requests because you are not filed in that state?

MR. COOPER: We have always tried to play it by ear. We do legal research to determine what powers the states have, and political research to determine what powers they might be able to impose on us whether they have them or not. There are a few states that will take as much as they can get but will back down. There are a few states that will not back down. A few states have laws that require you to follow their rules in their state. We have always taken the position that we could not write out-of-state trust business in Texas, and if there were a way around it we would have tried. There are some states which have not been big volume states for us but where we have gone along, particularly where we felt the state was enforcing the rules on all carriers.

MR. THALER: This is not the type of business where you volunteer filings except where it is required. The state of jurisdiction has jurisdiction, and the other states do not unless there is a specific provision in their code. For example, Texas requires a separate policy. There are a few states that require an informational filing of certain information like certificates. The general rule is that you file in the state in which your trust operates and do very little elsewhere unless specifically required by law or regulation.

MR. JOHN J. LYNCH: A number of people have commented on the dramatically different experience between medically underwritten and non-underwritten business. The normal breakpoints appear to be six, nine or ten lives. Have any companies moved above that level to fifteen or more lives?

MR. STRICKER: I know of at least one company, Home Life, that underwrites to fifteen lives. We underwrite to fifteen lives in Southern California.

MR. LYNCH: Why don't you do that in other parts of the country?

MR. STRICKER: In part, because it is a question of how much we would sell.

MR. LYNCH: Do you mean in regard to work for the agent or to the acceptance by the employer?

MR. STRICKER: The acceptance by the broker that this is what he has to do to sell a thirteen life case.

MR. THALER: If you are working with a captive agency force, the breaking point is not going to be critical. You may have a more delicate problem if you are going after brokerage business, since brokers are more sensitive to these underwriting requirements.

MR. TERRY L. HUFF: State Farm Life has just entered the small group business on a pilot basis. We underwrite up to fifty lives and, so far, we have not had any serious problems. We do have a captive agency force.

In regard to Texas, I thought I heard two different things. We have not gone nationwide yet, and we are hoping to go into Texas out of an Illinois trust. I got the impression from Mr. Cooper that that could not be done, while Mr. Thaler indicated it could be done with a separate policy in the trust.

MR. MCBRIDE: We also have an Illinois trust. What we have done is set up a parallel trust for policies of Texas employers. So we use two trusts.

MR. THALER: It is possible to use one trust with two policies. It requires a little restructuring of the wording of the trust, which should be designed to contemplate that. Texas does not require that you have a different trustee.

MR. HUFF: Mr. Stricker, you mentioned that you underwrite new employees. Do you use the same rules as when you are underwriting a group initially, or do you have a different type of underwriting?

Also, I would like to hear more discussion on requiring life insurance as part of the benefit package. One reason for doing this is profit. Are there any other reasons for requiring life, and what are the reasons for not requiring it?

MR. STRICKER: We impose the same underwriting rules for new entrants into an employer unit as we do when the case was originally sold. Our rules for requiring life insurance are essentially profit driven.

MR. MCBRIDE: We sell only through our own agents, and our approach is very different from what Irwin has described. We have a $50,000 maximum under the group policy. We have had very little pressure to raise it because our agents are encouraged to sell ordinary life products using the small employer group insurance as a vehicle to establish contacts with the employees.

MR. THALER: Mr. McBride has put his finger on the key issue. What are your company objectives? If you want to write group term, this small group product gives you a vehicle for doing that. The Guardian is a prime example of a company that has a tremendous amount of group life tied into their small group business.

Traditionally, group life has been a more reliable and consistent source of profits then medical insurance and that stabilizing factor is valuable. To the extent that you are being selected against by people who just want medical insurance, it has some underwriting value. While there are a few companies that do not require life coverage, the vast majority of your competition does. Thus, you will not have a competitive problem if you require life coverage.

MR. DONEL C. KELLEY: Each of the panel members has stressed the importance of monitoring financial results. What has been your experience in obtaining data efficiently and in the proper format? Have you relied on your data processing services area, or have you done it within your own staff?

MR. COOPER: To the extent possible we try to get our data on the claims side generated as part of the claims processing. Some problems are not always apparent. At one point, we changed claims managers, and the new manager just knew that we did not really mean to have the definition of incurred date that we were using, so he changed it. That really distorted our claim lag factors. We have had more problems than anything else with seasonal variations in claims causing difficulties in measuring claim backlogs in-house, but not paid.

On the premium side we have fairly good information. However, at times we find that when we try to break down premium by type of group, for select and ultimate studies for example, we run into problems in the way the data was built. It is a continually evolving process. Our actuaries have been able to use report generating languages and not overly rely on systems people. So if the data is properly defined, we can get at it; if it is not, we cannot.

MR. MCBRIDE: An outside administrator handles all of our claim paying and premium collection, and we rely on reports generated by them. It is not much different than working in your own company in that often they cannot react as fast as we would like. We are adding additional staff in our actuarial area to work with the data they provide.

MR. STRICKER: For the most part we rely on our centralized data processing area for reports, but we are about to put in a major experience analysis system. This will allow us to use simple programming languages to generate reports off of a claim data base.

MR. THALER: This is a key question that has been raised in light of fast changing claim trends and the emphasis on management. Integrated on-line data processing systems are becoming available for the management of this business. By integrated I mean that the data base that records the employer and employee information, the claim payment system, and a sophisticated report generating adjunct are all part of one system. This will allow the actuary to do the type of analysis work that should be done. Currently, most companies are struggling with systems which take a considerable amount of time to generate needed data and which do not always permit the proper type of analysis.

MR. JOHN P. COOKSON: I have noticed over the years a tendency to liberalize the eligibility standards. For example, allowing employees to opt out of the group if they have coverage through their spouse. What type of underwriting rules do you use in these cases? Also, what impact have you observed on the effect of the coordination of benefits (COB) provisions during the current recession, which has resulted in large numbers of layoffs?

MR. STRICKER: Our eligibility rules for employees with working spouses allow them to opt out of dependent coverage. Since we get evidence on almost all of our small group business, it really is not relevant. For groups of ten or more lives you would have to think that ultimately it will tend to worsen our experience. The current demographic environment forces us to recognize that there are a lot of working spouses who will want to opt out.

MR. THALER: As Mr. Stricker says, if you individually underwrite this business, the concerns about participation more or less go away. Much of the confusion that exists among companies trying to successfully operate in the business is because they continue to think of this in terms of traditional group insuance, instead of recognizing that this is a hybrid which is much closer to individual business than group business from the underwriting and experience standpoint

How about Mr. Cookson's question on COB?

MR. COOPER: My company has gone counter to what you might expect by actually being able to increase the savings by about a point and a half over the last eighteen months. I suspect that this is due to a change in claim practices.

MR. MCBRIDE: This does point out the question about basic monitoring of experience. We have a problem getting reliable COB information. Therefore, although we feel that the savings are decreasing, we cannot verify it at this time.

MR. THALER: Once again the answer here relates to systems support. If you have the right data base, you can start building COB information from day one by getting the information from the enrollment card. Once that information is on your data base, you can make use of it. You must have the data base and claims systems that can handle this.

MR. MCBRIDE: I have a comment on eligibility rules. We only underwrite the group, not the individual. If an employee opts out and later applies for coverage, we only have the protection of a ninety day waiting period for eligibility. Although we do not know if we have a problem yet, we see this as a concern. The frequency of requests for exceptions with respect to the waiting period is an indication that more people are losing their duplicate coverage. The prevalence of divorce is also impacting this area.

MR. THALER: Are you rethinking the adequacy of a waiting period versus individual underwriting?

MR. MCBRIDE: I just wanted to comment on the difference in underwriting. If you underwrite each applicant, even after the case is issued, it affords more protection. We are relying on a longer waiting period for coverage on late applicants.

MR. LEONARD KOLOMS: Mr. Cooper, you were introduced as an actuary from a company which felt it could not make a profit in this business. But you have expounded on what a company should do to make profits. How does your company's operations differ from how you feel so that you still could not make a profit?

MR. COOPER: I did not mean to imply that I felt we could not make a profit. Recent actions taken by my company to minimize the amount of health insurance have more to do with a general distaste for casualty cycles than anything else. We have not been doing much underwriting, but we are doing most of the other things I have discussed.

Through the 1970's we had a good history in the small group business. Our inability to keep up with trend factors the last few years, and we are not alone in that, has left management with the feeling that we would rather be in the life insurance business than the casualty business. You can make a profit in small group business, but not consistently every year.

MR. THALER: I would like to add a consumerism note. You may recall that in Canada many years ago province by province, and later the federal government, took over medical expense insurance. There have also been in-roads by the Canadian government into the life insurance and pension business. A concern that the insurance business in the United States should have is that there is an obligation to provide this coverage to both large and small employers. Otherwise we will be abdicating to the government, and the in-roads will not stop there.

MR. WILLIAM E. JAMES: I am a Canadian, and it is interesting to note that this consumerism aspect is almost always brought up. For example, with income replacement many companies say that if we do not write this business the government will come in and take over. But when they talk about what they will write, they are trying to skim off the top and leave the blue collar and poor risks to someone else. Certainly you want the business,

but only the best, and you hit everyone with exclusions and declines so that you get good experience. You are actively writing the business, but you get very low coverage rates of the general population.

MR. GEORGE HOPKINS: To comment on a point brought up earlier, anyone considering going up to twenty or thirty lives should be aware of the federal laws that kick in at fifteen lives. For example, employers are required to provide maternity coverage. You could do it either as an option, or on all your cases.

Most of our carriers just go from two to nine lives, but some go much higher. We have not seen much business over ten lives, and most of our business, by number of groups, is in the two to five life range.

Mr. Stricker, with your relatively large life insurance amount requirements, what percentage of your premium is life insurance?

MR. STRICKER: On groups of less than ten lives it is about 30%.

MR. HOPKINS: Do you set that as a goal, or is that just what it came out to be?

MR. STRICKER: That is what it is now. Ten years ago it was 30% on groups over ten lives; now that is down to 20%. The dynamics of medical care inflation are resulting in a diminishing percentage of life premium to total premium. Our targets are set more as a function of what we would want our experience to be on the total block.

MR. HOPKINS: We pay a lot of medical claims, and I would be interested in knowing what percentage of claims savings results from COB provisions?

MR. STRICKER: Our savings on COB are virtually embarrassing. A rule of thumb savings is 5%, but there are a number of companies who are a little zealous in this area and are getting savings of 9 or 10%.

MR. COOPER: The past few years were running about 5 1/2%, but in the last eighteen months we have raised that to 7%. We are fairly tough in this area, and we are happy with our results.

MR. MCBRIDE: We do not have a handle on our under ten life groups, but on larger groups our savings are 7 to 8% of claims.

MR. THALER: We have seen examples that run over 10%. It is a question of how hard you work at it and what you have on your data base. It is a big item that can more than pay for your claim operation if you do it right.

MR. GEORGE CALAT: We recently moved to a quarterly selling rate on our small groups under fifty lives. We do not have a twelve month rate guarantee. What are the objectives of going to a more frequently than quarterly rating cycle? Are quarterly rates designed to last a quarter, with new rates for the next quarter, or are the rates designed to last twelve months with the option to increase them whenever experience indicates?

MR. COOPER: On our MET business we try to set a rate that will last six months. We prefer not to raise rates quarterly unless absolutely necessary. On our larger group business, still small group but non-MET, we have given annual rate guarantees. But, on a formula basis, we change rates for new cases monthly so that this month's rates can go up 1 1/2% to 2% for quotes next month. As experience develops, we adjust it to keep it on an even keel. We also had the problem that the word would get out that a rate increase was coming almost before we knew it. We would have a whopper of a month and then the next month, when the new rates were effective, we would see very little business for awhile and we would be locked in for twelve months. So we went to monthly rate adjustments on new quotes.

MR. MCBRIDE: Our rate for new business changes every six months, and each unit only gets a six month guarantee at that rate. Our objective is for that rate to last six months.

MR. THALER: We have a large company client that is operating on a three month rate adjustment for both new and renewal business.