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GROUP INSURANCE UNDERWRITING AND SELECTION ISSUES

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1. What changes in the group underwriting and selection processes are taking place? Can medical care costs be controlled or at least limited through plan design?

2. Is there a significant movement to non-traditional benefit programs such as Cafeteria Plans and Preferred Provider Organizations?

3. What new financial processes or arrangements are being employed? Is there a drift toward tighter experience monitoring procedures coupled with prompt rate adjustments?

MR. ROBERT A. HALL: Our panel discussion this afternoon is intended to cover some of the issues now taking place that currently do, or presumably will, affect group insurance underwriting. This particular panel is not a teaching session. Hopefully it will be an information forum. Your own comments and perspectives, as well as questions, are welcome.

Our panel will follow the program outline. George Mayo will discuss some of the front-end underwriting issues, which deal less directly with rating and financial matters, but are concerned more with design and plan limit provisions. Following George, I will cover some of the developments occurring in what has been termed the non-traditional benefits area. Dale Ethington will complete the panel discussion by covering some of the prevailing back-end techniques. Primarily, he will cover some of the changes that seem to be occurring with respect to rating, re-rating, and those other issues that have a more direct link with the financial aspects of a group plan.

MR. GEORGE F. M. MAYO:

I have been asked to start at the beginning - namely, at the design and quotation stage of a group plan. Thus I will be discussing the criteria that are emerging in the two areas of plan design and underwriting of risks.

On one important facet, I am going to have to plead ignorance. At present, the buzz-word is "cost containment". In Canada (and I represent the "Canadian content") we don't even know what the word means. This is not unnatural - its principal impact is on the major medical program, and the Canadian medicare system has removed actuaries and insurers from the forefront of the battle. There is emphasis on cost containment, but in Canada, it is at the political level far more than it is south of the border.

The Canadian major medical scene is similar, perhaps, to the American medicare supplement scene, and we have made just the same mistakes. First dollar coverage, no co-insurance and unlimited benefits all present a trap for the unwary underwriter. For the larger group plans, this may be an expense which can be passed on. For example, we had one plan with an unlimited benefit, and one employee of the group had 3 children with cystic fibrosis. The resultant claims for this family amounted to "only" $2 per month extra premium on the married rate - for every employee of this group.

However, this now brings up the first of the emerging problems I wanted to discuss. Both in Canada and in the U.S., we are seeing increased emphasis on the "small group" - variously identified as 3-25 lives, 5-25 lives or even 1-25 lives. These groups, whether underwritten alone (I don't know anyone who does that), or in a pool, or in an "association" case, or in a true multi-employer trust, present special underwriting problems.

These small groups (for which there used to be a few specialized insurers only) often offer a very full package of benefits - life, income replacement, AD&D, health and dental, often with dependent life and optional life as well. This poses a great problem in anti-selection. There is usually one person very much in control - let's call him Mr. Big, and Mr. Big is very likely to buy what's best for Mr. Big. If Mr. Big has 5 children with badly misaligned teeth, he is going to want a plan with orthodontia - and so on.

For this reason, most insurers offer small groups only a selection of "packages". While these packages cover a good range of plans, the tendency is to offer the risky benefits (like Mr. Big's orthodontia) only in a very full package. In Canada, as well, we can (at present) use medical evidence for such benefits as life and LTD, and thus avoid some of the more expensive forms of anti-selection. Perhaps one of the other panelists might like to expound on the evidence problem in the U.S. for groups under 10 lives.

However, it is <u>not</u> usual to be able to get evidence on dependents; we will not catch Mr. Big's 5 toothy children, or his wife who requires special nursing on and off for months at a time. For this reason, the health and dental coverages present special problems.

On larger groups, you can identify problems by investigating past experience. But on smaller groups, (a) you can't get information on past experience and (b) it's not credible, even if you can. I must admit to being a bit of a maverick on that last point. To me, BAD experience always has credibility, and TWO consecutive YEARS' bad experience has quite high credibility.

If you believe that, how do you cope with renewal underwriting, or even initial underwriting? The traditional view is that small group benefits are all pooled, and everyone pays the pool rate, adjusted perhaps for objective factors such as age, location, occupation, salary and so on. However, if you do that, you are surely encouraging the bad cases to stay with you, and the good ones to go.

On renewal underwriting, our approach is to classify groups partly on the basis of past experience as "manual", or "80% of manual", or "120% of manual" and so on. If we lose cases to our competition, at least they are the ones that used to hurt us.

That approach doesn't work on new cases. So far the only defense we have tried against deliberate anti-selection, or "rate-hoppers", is to refuse to quote on any group which has changed carriers twice in the last 3 years. It's a poor defense, but it's the best we've found. We are also pressing very hard for what most of the U.S. companies have - the right to change rates in any policy month, even within 12 months of issue. Our sales force is fighting hard against that. I personally would be interested to know of Canadian companies who have been able to introduce such a provision - I know of at least one, and to see whether this will be a growing trend. My company has got it into some new policies - but not all.

So far, I've said very little about LTD - quite deliberately. LTD has problems all its own, particularly at the present time. We are seeing many companies complain about their LTD experience - and, in a sense, we are seeing the truth of the conventional wisdom about disability income benefits in a recessionary environment. However, even this blanket condemnation seems to be a little short of the truth. In my own company, we have seen some quite unexpected quirks. We are seeing some policyholders with excellent LTD experience, even some in very troubled industries; we are seeing bad experience in areas and industries where there is no recession. In general, our small groups are less troublesome than our big groups.

What underwriting techniques will work? Perhaps this is the time to go back to basics; we have to look for low replacement ratios, and in particular, shun COLA's. Well, maybe COLA's aren't all bad, but certainly we have too many in the loss column to love them. One other thing we can do is to increase our efforts at the other end.

The other end, of course, is claims control after disability. My assigned task today is to discuss the underwriting process only up until the issue of a policy, but what you do in claim control MUST affect your underwriting judgment up front. In today's market, you have to be extremely wary of underwriting LTD, unless you have great confidence in your claim control program. You must be assured that your rehabilitation efforts are starting as early as possible, even during the waiting period, and that they are effective. Good rehabilitation personnel are hard to get, but you will need them if you are to have underwriting freedom.

Secondly, your risk selection process needs to be finely tuned. If you find a pattern of high risk occupations, these should be rated appropriately. My company hasn't really found such a pattern, apart from the conventional one which includes groups with a high blue-collar content, teachers, and the like. If you have found greater sophistication, congratulations. You have found an edge - and that's what's needed in the environment today.

MR. HALL:

For the second part of today's discussion, I will turn to the underwriting and selection issues surrounding a set of newer, non-traditional benefit programs.

The non-traditional approaches I want to consider are flexible benefits (also known as cafeteria plans), health maintenance organizations and, briefly, a very new development: preferred provider arrangements. The presence of one or more of these non-traditional approaches within an employee benefit program presents the underwriter with some additional

selection and underwriting considerations. The benefit approaches are relatively new, especially the preferred provider arrangements. Experience in dealing with these plans is only now beginning to emerge. There is, however, a common characteristic in these arrangements that adds a new dimension and challenge: the employee plays a dominant role in deciding the type and level of benefits which he or she will receive. This single characteristic is most directly responsible for the emergence of some new or changed emphasis on existing underwriting and selection issues.

This can be illustrated quite effectively by analyzing the flexible benefits concept. I'll go into more detail with flexible benefits both as a point of illustration and because, at present, there is somewhat more diversity. Then I'll only briefly cover both HMO's and PPA's.

Now, let's look at flexible benefits. In contrast to the traditional group insurance approach where an employer provides a single plan of benefits for all employees, the flexible benefits plan provides employees with a means of using their pre-tax benefit dollars to select the benefits most suited to their individual needs. This concept has been around for over a decade. However, in the last few years, there have been a number of employers that have adopted flexible programs. Furthermore, it seems many employers are now beginning to actively consider this non-traditional approach.

Why is there such a growing interest among employers in offering employees a choice of benefits? There are a number of environmental influences which seem to be causing employers to consider flexible benefits. Essentially, these can be categorized into three major driving forces.

First, consider the employees who are to be insured - here there has been a marked change in the demographics of the workforce. The tranditional employee benefits plan was developed for a family unit consisting of a male breadwinner with a non-working wife and children. Today, however, because of lifestyle and demographic changes, only 20% of all employees presently fit this traditional mold. The traditional benefits plan designed to serve a more homogeneous workforce is simply no longer appropriate for today's diverse workforce. Flexible benefit designs can better meet the diverse need of this new workforce.

Second, from the employer's side, there is a need, really a demand, to control the cost escalation of the total benefit package. Benefits have grown to almost 40% of payroll with only little sign of abatement. In some flexible benefit programs, the employer shifts a portion of the benefit cost escalation problem to his employees, breaking the direct link between the cost of benefits offered and the employer's benefit expenditures per employee. Right now, it is not clear whether this approach will work over an extended time, but some employers are trying it. This reason then probably is the major force behind the interest in flexible benefits today.

The third major force is the changes in federal tax law, specifically, Section 125 "Cafeteria Plans" and 401(K) "Cash or Deferred Arrangements". These laws permit employees to make more tax effective use of their benefit dollars. Time does not permit a discussion of these laws in detail, but they do constitute a major consideration in moving away from the traditional single plan approach.

The more common ways of designing flexible benefit plans include:

- modular or mini-flex
- mix and match, or trade-off
- cafeteria or free choice
- high/low medical options
- core plus options

In general, these different approaches follow the fundamental principle underlying flexible benefits: they all give choice to employees. As a consequence, the employee becomes the principle decision maker for his own benefit package.

Core plus is one of the more popular approaches. It offers considerable flexibility for employees. Its introduction also allows the employer to address some of his needs and concerns. It's a good basis for comparison. The employer may provide all of his employees with a non-contributory minimal core package. In addition, flexible credits which each employee can "spend" on additional benefits are also provided. For example, the core may provide all employees with at least catastrophic medical coverage, some life insurance, sick pay benefits, vacation and a pension plan.

Options which employees might select are first, additional insurance benefits: for instance, more life insurance, a richer medical plan, a dental plan, and long term disability. Next, the employee can direct flexible credits to a qualified profit sharing or savings plan. Employees who do not want more benefits can elect to take their credits as additional salary, which then becomes taxable income. A somewhat more sophisticated plan might include the purchase of additional vacation days, and other benefits such as dependent child care, legal services and a medical reimbursement account.

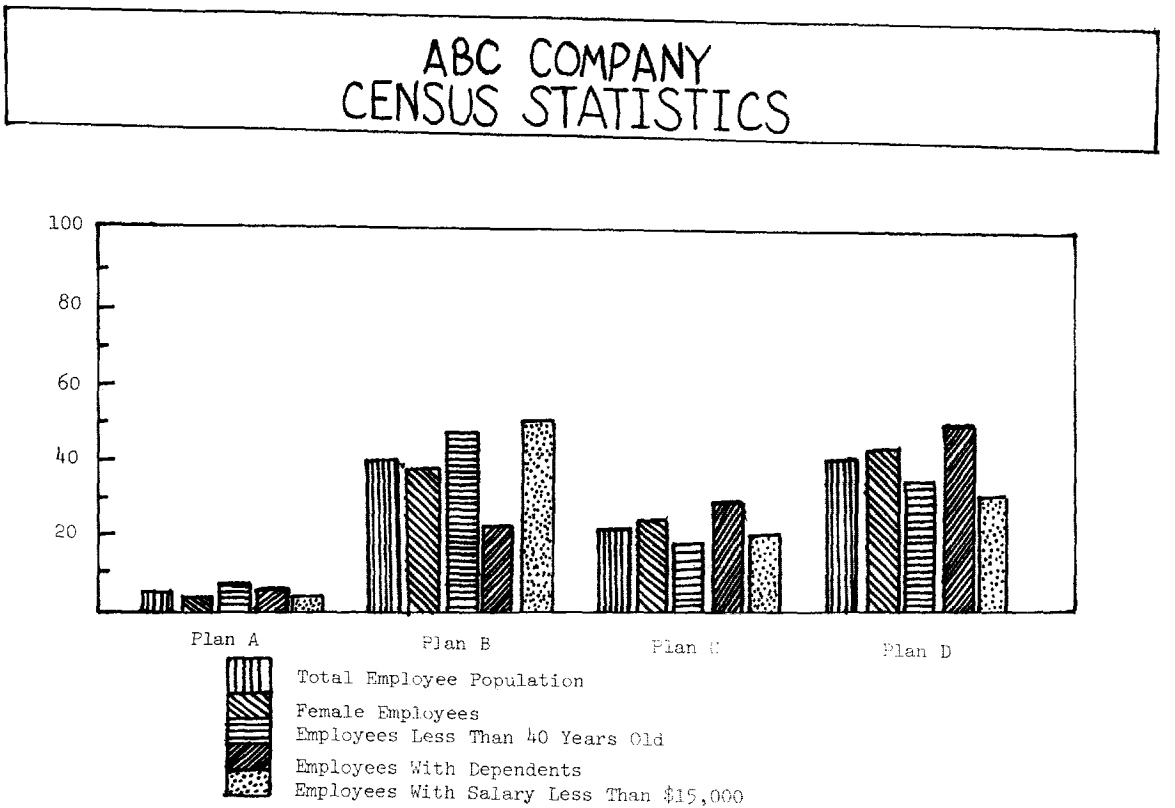
Now, when we see an arrangement like this, the first underwriting problem that surfaces is adverse selection. The question really is not "will there be adverse selection?", but "how to deal with it?"

First, let's look at an example of how selection occurs. In this flexible program, an employee has a choice of four comprehensive medical plans. Plan A is a $500 deductible, 80%/20% coinsurance plan. Plans increase in value to Plan D which is a $100 deductible, 100% hospital, and 80%/20% coinsurance on all other expenses. (See table on next page.)

This table illustrates how employees in total elected coverage, and shows the selection breakdown by sex, by age, by dependent status, and by salary. Clearly, it is quite likely that there will be different selection results solely related to census characteristics.

We can also expect selection based on an individual's knowledge and concern about his/her health condition and probable medical care utilization. And finally, each employee will make their own very subjective decisions on their personal evaluation or perception of the plan alternatives or choices they are offered. At present we have inadequate tools to measure effect here, much less ability to predict the effect of selection.

But employee choice will certainly result in some adverse selection and there is a cost associated with it. How do we deal with it?


ABC COMPANY
CENSUS STATISTICS
100
80
60
40
20
Plan A
Plan B
Plan C
Plan D
Total Employee Population
Female Employees
Employees Less Than 40 Years Old
Employees With Dependents
Employees With Salary Less Than $15,000

Well, there are some underwriting techniques that can be used to deal with potential adverse selection. These can be categorized into -

- Plan Design, which are the general provisions of benefit coverages.
- Election Rules, which restrict employee choice at enrollment and re-enrollment.
- Pricing, or loading employee contributions to recover the cost of selection and to influence employee election patterns.
- Employee Testing, or anticipating employee elections by means of surveys.

Let's briefly look at each of these techniques.

(1) Plan Design incorporates a number of approaches:

   (a) Packaging, or combining coverages, e.g. combining dental with one or more of the medical plan choices - i.e., structure the plan so that dental is not available by itself.

   (b) Maintaining meaningful benefit differences between plans so that selection is based on perceived differences in plan provisions and not strictly on price or contribution differentials.

   (c) At a minimum, providing cost containment provisions in the richest medical plans.

   (d) Designing plans based on different employee needs, so that choice is not based strictly on financial or health condition criteria.

(2) There are a number of considerations surrounding the employees' opportunity to re-elect coverages after the initial enrollment. These are some of the more common election rules:

   (a) Evidence of insurability required for increases in life insurance amounts.

   (b) Changes permitted only once a year. Exceptions are usually made for significant life events such as marriage or divorce.

   (c) Limiting yearly increases in benefits to only the next richest level.

   (d) Providing a deferral period between the date the coverage is elected and the effective date of coverage.

(3) Pricing is an important element in dealing with adverse selection. Clearly, it is desirable to try to account for all of the adverse selection components in our expanded pricing formulas.

(4) Employee testing is not commonly used in group insurance underwriting and pricing. Clearly, in these open choice plans, information obtained from a specific survey will provide a better means to evaluate and rate the overall group, than just using census data by itself.

Results of employee testing can be used to design the benefit options, develop the election rules and make pricing more accurate.

In summary, then, we have plan design, election rules, pricing techniques and testing. The basic point is that with the evolvement of the flexible benefits approach there is the need to deal with a wider range of new selection and underwriting issues.

I will now turn to the effect of health maintenance organizations on the design and underwriting of indemnity medical plans. HMO's are not new, but what is new is that in some areas of the country, HMO's are achieving very significant penetration. Where an HMO has made significant penetration, the impact of the HMO on the indemnity plan should not be ignored.

In situations where employees can elect and reverse election between an indemnity plan and a pre-paid HMO, and where the HMO participation is significant, there is a real possibility for meaningful selection to occur. Essentially, these are the same selection opportunities and issues that are present with flexible benefits. The choices are more limited but the selection issues are very much the same. Clearly, the pricing and underwriting of the indemnity plan should consider what the HMO may draw away from the indemnity plan. At a minimum, one must ask, what are the specific census characteristics and what are the presumed health conditions of these participants?

Now briefly turning to preferred provider arrangements. This is a very new development at this time in California. The very first question is, "What is a preferred provider arrangement"? The HIAA has a task force on PPA's and I'll use their definition from the task force's March 23, 1983 draft report.

- A preferred provider plan is an arrangement by which an insurer or other third party contracts with health care providers either directly or indirectly with or without the assistance of intermediaries.

- The contract is to reimburse the providers for health care services rendered to the payor's insureds/beneficiaries. It is not a contract to provide medical services.

- A preferred provider plan generally contains incentives for the insured/beneficiary to secure the services of a contracting provider over a non-contracting provider. Such incentives generally include alternative reimbursement levels.

The task force report notes, and I quote, "It is essential to discuss the concept in terms of an arrangement and not in terms of a specific entity or organizational structure."

PPA's are very new and there really is no way to tell what will prove to be the critical selection and underwriting issues. But, I'll suggest some of the potential issues.

(1) What criteria should be used to select providers?

(2) What "arrangements" should be made with providers?

(3) What incentives should be offered to insured employees?

(4) How will employees select?

(5) How should performance be monitored?

I would guess that as experience is gained with these arrangements, this list will change and possibly expand.

In summary, we've looked at the selection and underwriting implications of three non-traditional plan approaches. We probably need to make some fundamental changes in our thinking when dealing with these arrangements where the employee takes part in the decision making over what type and level of benefits he or she will have.

In a flexible benefit plan, employees decide among choices of indemnity plans; when an HMO is offered, employees select between the HMO and the indemnity plan; and when a preferred provider arrangement is present, employees decide where to get their medical services at the time they need the care.

When more selection opportunities exist, underwriting is more important and generally more complex. For the moment and at a minimum we can only be aware of these changes that are occurring. In time we will learn to deal with these now new non-traditional approaches which will likely become more prevalent in the future.

MR. DALE F. ETHINGTON:

Group insurers have made many changes in their practices in the last year or two. I believe some of these changes represent new procedures, but most of them are really tightening up of existing procedures. I will go through the questions in the program today and point out what I see as recent changes. Some of these are trends, while others may just be swings of the pendulum. I'm not sure that I can accurately characterize which of these changes are long term trends and which are simply of a temporary nature. These observations are based on my experience with what Metropolitan is doing, and what I have observed in the marketplace in the western United States.

With respect to selection processes in group underwriting, I've noticed that insurance carriers have become more cautious in certain markets. It appears to me that many carriers are moving more conservatively with respect to high risk business, such as multiple employer trusts, and with respect to public bid business such as states, municipalities, and school districts. In many instances it has been hard for these groups to get very many bids from insurance carriers when that kind of business has been up for bid.

The other items that I've noticed in this area are that more optional life plans are going into effect, and that the participation requirements and

amount restrictions have been loosened up. In other words, we are seeing larger amounts with lower participation requirements in the group life area, particularly optional group life.

Moving on to plan design, there are only a few areas where I've seen a plan design change which I thought really was in the neighborhood of controlling costs. Most of the plan designs seem to just shift the cost from one area to another; they don't really do much to control it. The area that I think that we have made progress towards controlling costs is in prescription drug programs. We have card systems through which we can control claims and the expense of processing claims. Wholesale and mail order drug systems, where maintenance drugs are purchased through the mail, can also be significant cost savers in prescription drug programs.

The next topic in the program is on preferred provider organizations, or PPO's. I'd like to give you a little background on what the activity has been in California. MediCal, which is the indigent medical care state program in California, has the authority to go out and negotiate with hospitals to determine who will provide benefits for MediCal patients. A great number of hospitals that used to provide care to MediCal patients are no longer listed as reimbursable. If you are a MediCal patient, you have to go to a hospital that is on the approved list if your expenses are going to be paid. The hospitals are quite upset by this and are challenging MediCal on their actions. The result of all of this is that we became aware of the fact that insurance carriers also have the right to enter into these kinds of contract negotiations in California. This has been done in a way that I thought was backward, although it's not clear what is the right way to develop these programs. There are some people who think that you have to organize the hospitals before you can organize the physicians since the physicians are affiliated with certain hospitals, so if you organize a hospital network you'll have an automatic physician network. Since January 1, 1983, you can negotiate with physicians and, I believe, starting July 1, 1983, you can negotiate with hospitals. For more details, you may refer to Assembly Bill 3480 in California.

I don't know of any real PPO's that exist in California today. CPHP, the California Psychological Health Plan, provides psychiatric benefits in a PPO-type of arrangement, but is really somewhere between a closed panel and a PPO. Actually, since the CPHP provides very rich benefits for outpatient psychiatric services, they have had a hard time getting very much interest in their plan because it seems likely to increase claim costs, rather than decrease them.

In any event, there are a couple of these PPO's that are close to being up and running now. One of them is the California Health Network in the San Francisco Bay Area, which is made up of seven hospitals and a staff of doctors. I don't know if all the doctors on the staff will be participating, or if only selected physicians will be, but at this point everyone thinks that this represents a great opportunity to make these negotiations work and to control costs.

There is also a great interest in the employer community to do something in the PPO area. I'm sure things are going to be done; whether they work or not, I would urge any actuary who has an opportunity to get involved in the design of these things to take advantage of it. I'm sure there are going to be a lot of unsound ideas that would otherwise be developed, and then we would be stuck with the problem of trying to rate them properly.

Another item that is somewhat non-traditional is plan experience analysis and advice services. These are offered to employers by "experts" who will analyze the insurance carrier's claim payment practices and utilization abuses on the part of the medical community. These people will also perform very indepth statistical analyses and pinpoint where the problems are - hospitals, physicians, certain diagnoses and so on. I am sure a lot of you have read about the DRG technology, for which there is a lot of employer interest. I think we will be seeing more and more of these analysis services, which is likely to lead to savings in plan benefits, and may also result in plan design changes. One of the ideas suggested, for example, is that if you have a mandatory second surgical opinion program, you really should determine what surgical procedures you want to include in that program, based on a detailed analysis of your experience under that program. Thus, this type of analysis is based on the actual medical practice, and may result in alot of plan design changes that will be beneficial in cutting the costs of medical care.

The last item in the program deals with financial arrangements. I will discuss the changes that I have seen in financial arrangements over the last year or two.

The first change is that many customers at the lower end of the large case market are moving away from experience rating and towards pooling. In the past, the trend had seemed to be that everybody wanted to be experience rated - they wanted their dividends if they were having dividends coming to them. There was always pressure to move to a more experience rating dividend credit accounting on these cases, but in the recent past there have been more of these policyholders who have been willing to go to a non-participating approach in exchange for some rate relief.

The next financial arrangement change that I've noticed is that there are more premium stabilization funds being held. Current surplus, instead of being paid out as a dividend, is being held by the insurance carriers. This is probably primarily due to the Stop Gap Tax Law, where there is a tax on dividends paid. But I believe also that, in some situations, it is because of the rapid increases in medical care costs that the employers in renewal negotiations are willing to let the carrier hold the surplus in exchange for rate relief.

One of the changes in financial arrangements which actually is pretty new first came into being this year and is strictly a California phenomenon again. It is the California Discontinuance and Replacement Law, otherwise referred to as Senate Bill 366. There have been some court rulings that interpreted this regulation as saying that insurance carriers who have the necessary language in their contracts with employers can walk away from any contractual medical care liability on disabled employees. The contract may say that they have a liability for disabled employees, but they can walk away from that liability if the contract is cancelled and is written by a new carrier. This matter is currently under study by the industry, and apparently everyone would like this law to be reversed. As the law and its interpretation now stand, an insurance carrier has to be very careful when writing a new case in California. There may be significant claims that may have to be assumed by the new carrier. For example, an unscrupulous carrier insuring a group with a large, ongoing disabled claim could raise rates abnormally high, purposely irritate the policyholder, and encourage the case to go out to bid so that the new carrier will inherit

the liability for that disabled life. Hopefully, examination of examples of this kind of potential abuse will force this law to be changed.

Some of the more traditional financial arrangements that are being utilized more extensively are retrospective premium arrangements. I've noticed a trend towards larger retrospective premium arrangements. I think carriers use them to reduce their risk, and I believe also that they are used to reduce the likelihood of dividends being paid out on experience rated contracts, which is at least partly due to the tax implications that go along with payment of dividends.

Another new twist in financial arrangements is the return of the open and unreported claim reserves to the policyholder. The primary purpose is to return the funds to the employer, but there is a secondary purpose, which is to reduce the insurance carrier's risk. In one type of plan, the insurer retains the liability for the run-out of the claims. If the case is cancelled, the insurance carrier has the liability for the run-out but the policyholder must pay a sum of money, which is either fixed or variable, to the carrier to pay for the run-out. The plans that operate on a variable payment basis offer the insurers some opportunity to reduce their risk. In the second type of plan, the employer gets the funds and the liability - the insurance carrier has no liability whatsoever. And finally, there is a trend to requiring special payments upon termination. This special payment may be a fixed amount, it may be a variable amount, or it may be an extra month's premium.

Since many customers now have financial arrangements where they are holding part or all of the reserve liability, or have delayed premium payment provisions or retrospective premium arrangements, there has been an increased concern with the policyholder's financial condition. Can that policyholder actually come up with the money? The Metropolitan has increased its monitoring of the financial liability of its customers when these arrangements are outstanding. I believe other carriers have been doing the same. We are also more cautious in extending these arrnagements to new customers, particularly in a bid situation because often times the case is yours as long as you are willing to make these arrangements. Likewise, you may feel it is necessary to discontinue existing financial arrangements with your existing policyholders. This will probably irritate your customers, and you may lose some of them. This has been a difficult thing for carriers to do, but they have tightened up in this regard. I know from my own experience that you don't really want to go into bankruptcy proceedings with those kinds of arrangements in effect because your chances of getting very much money out of them is pretty much nil.

The next item on the program is the trend toward tighter experience monitoring procedures. Metropolitan has expanded its monitoring procedures - we monitor inflation and utilization trends very closely. We are now actively monitoring inflationary and utilization trends to avoid getting caught asleep like we have done a number of times in the past.

On a monthly basis we examine the medical care components of the CPI figures. We then adjust the CPI figures for seasonal variations, and we weight the components to reflect the benefits that we're providing. We also look at the CPI figures for different major geographical areas to see if there is some difference emerging in different parts of the country.

In addition, we monitor our own inflation experience on a monthly basis. During the Voluntary Wage-Price Stabilization Program we established a procedure for monitoring the actual monthly experience of a representative sample of our larger group customers. We found this was a really valuable technique for us and have continued it because we are thereby able to compare the actual exhibited trend on what we feel is a representative block of business with the CPI-based trend factors. We think that this has increased our ability to respond more quickly, and to have a higher degree of confidence in the accuracy of what we're doing.

We have also increased our monitoring of the emerging experience on our larger cases on a case-by-case basis. We think that this allows us to better plan for implementing large rate increases for these cases, and also to prepare our customers for those rate increases in advance.

Our claim department has adopted programs and procedures to monitor the accuracy and timeliness of our claim paying operations. This is to assure that they are being operated soundly and smoothly, and that acceptable performance statistics can be presented to policyholders. As a by-product, we've been able to use this information in our renewal underwriting to judge the accuracy of the claim payments, and to observe the timeliness of the payments of various claim operations.

The final topic on the program is the concept of prompt rate adjustments, which may be a direct result of the monitoring techniques that I've just mentioned. In the past, it was very common for large group cases to have rate changes that were deferred for three months or more after the renewal date. But with the rapid escalation of medical care costs, it has become very difficult for us to collect an adequate premium during the policy year. Thus, there has been a strong trend away from deferring renewal rates. This trend probably started during the Voluntary Wage-Price Stabilization Program, and has continued even more strongly. In those cases where a renewal can't be settled by the rate change date, it is now a lot more common to require that the rate increase be implemented effective retroactively to the original rate change date.

I have also observed an increasing reluctance on the part of the existing carrier to defer a requested rate change when a case is out to bid. This non-deferral trend can be very clearly seen in our new bid situations, where it is rare to find medical care rates that are guaranteed for more than twelve months. We still have brokers and specifications requesting fifteen month rate guarantees, but it is becoming increasingly rare to get carriers that will actually agree to guarantee those rates for fifteen months.

Another trend in rates is instances of rate guarantees of less than one year. In the past, medical care rates on larger cases were always guaranteed for twelve months, but it is becoming more and more common to see guarantee periods on medical care rates which are less than twelve months. In some cases carriers have reserved the right to change rates on a month-to-month basis. This practice is more prevalent in the smaller case market, and its extension to the large case market has been something of a surprise. It appears that the large policyholders really don't care for it very much; nonetheless, it is starting to occur anyway. For some cases, rate guarantee periods of less than twelve months may be the key to reaching a realistic compromise between the insurance carrier and the policyholder with regard to rate increases.

I have heard that some carriers have approached their policyholders and asked them to voluntarily raise their rates in the middle of a policy period because of adverse experience. The carrier has no contractual right to make this change, and it is unlikely that the carrier would be successful!

Two more items in this rate adjustment area have to do with plan revisions. In the past, modest upward plan revisions would require modest rate increases, but, because of administrative reasons, the rate increases were waived. This waiving appears to me to be much less common today. Carriers either insist that the rates change, or they increase the retrospective premium arrangement to cover this extra rate until the next rate change date.

The second revision area is what I call downward plan revisions - I believe that carriers are attempting to be more careful in the credits that they give in this area. For example, a policyholder might increase the medical plan's deductible from $100 to $200, and maybe change the out-of-pocket limitation from $500 to $1,000. Metropolitan's underwriting operations has been exercising more care to make sure that we don't overcredit in these situations, and that we fully reflect any carryover provisions and any provisions relating to those people who have already satisfied existing plan deductibles and out-of-pocket limitations.

There are other factors which should be examined when calculating rate credits. One factor is determining whether there is alot of duplicate coverage because of two family members working, each with coordination of benefits. Another factor involves the trend of some employers requesting relatively large increases in the deductible on their medical plan, but they intend to pay for the benefits for the first portion of the deductible themselves. I heard in a workshop this morning there are also "pirate companies" which will sell insurance in that corridor. In any event, when you have these types of situations, you should be aware of any deterrent effect that might occur. In other words, a large deductible will normally deter people from getting medical care, but if the deductible is being "filled in" for them you should expect to see a different utilization pattern than you would otherwise expect.

Finally, I'd like to comment on three other minor changes that I've seen carriers making largely because of their financial results and escalating medical care costs. The first of these changes is primarily in the large group market. In the past, many insurers were encouraged by their policyholders to maintain lax claim processes. They didn't want you to resist claims, they just wanted you to pay the claims. The pendulum has swung back, and now the customer wants to make sure that you are careful in your claim-paying practices. Thus, the whole claim administration environment has moved to one of not paying benefits that are not required. We have found that we also have to tighten up our contract language so we can defend these more aggressive actions in court. Many of the contracts that I think are around today would not stand up under very agressive claim cost control through administration.

The two other changes are really back-end items; in other words, courses of action which don't require the customers' agreement. The first is, if you are a mutual company, you can change your dividend formula, or, if you are

a stock company, you change your experience credit formulas. You can raise expense charges, lower interest credits, raise interest charges, raise risk charges and modify reserve factors. An example of this is making a tax charge on dividends.

Finally, carriers are not only trying to make their charges cover their expenses, but are attempting to reduce those expenses. Many carriers are trying to achieve this through consolidation in their claim operations, which hopefully will improve service as well as decrease expenses.

In summary then, I believe that insurance carriers have, over the last year or two, tightened up considerably on their underwriting practices. This tightening up has been successful because it was really absolutely necessary in order that insurance carriers continue on a sound financial course in our relatively risky group insurance business.

MR. DAVID V. AXENE: I have a couple of observations and questions regarding PPO's. First of all, it seems that most of the PPO work has resulted solely in a fee discount, either from the hospital or the physicians. This arrangement doesn't really refer to a whole lot of utilization controls, and it seems that, in order to make a PPO work, you should employ some sort of utilization controls. Because the PPO usually has more liberal benefits, it is likely that the increase in utilization will offset the cost savings. I would like to know if any of the Panelists have seen PPO's that actually do reduce utilization, and if they do, aren't they really like a self-funded HMO?

MR. ETHINGTON:

I think you're right - that's what the struggle has been with the PPO's. They have the right now to negotiate, but nobody knows how to do it. They don't know how to structure the thing to really produce the kinds of savings that they hope will emerge. Most agree that some type of utilization review is necessary, but a good technique to accomplish that review has not yet been developed. If the arrangement covers home and office visits, it's very hard to do peer review on those visits.

Likewise, once a PPO is up and running, it is very difficult to keep somebody out of the preferred provider network. You should have some criteria for having people come in and out of the network. Thus, as far as PPO's are concerned, the opportunity is definitely there. Many employers are looking to PPO's as possibly a significant way to cut costs. But no one knows yet how to do it - no one has found the right ingredients to put together.

MR. RICHARD BILISOLY: I have a question that maybe Mr. Hall can answer. I was interested in your election profiles under Flexible Benefit programs. It certainly does look as though there will be some anti-selection, and I wondered if you had some cases that had been insured under such a program for a year or two. Could you not go further and ascertain the exact cost of anti-selection by first acting as though all employees and their dependents were covered, let's say talking about medical plans, under Plan A, then under Plan B, then under Plan C, and finally under Plan D, and then calculate the claim costs under each supposition, and then compare those to the claim costs that actually emerged with the selection, and finally ascertain the total overall cost of the anti-selection?

MR. HALL: Yes, you can do that. It gets to be a very extensive set of calculations to make if you have a relatively extensive and complex flexible benefits program. First of all, there aren't that many programs that have been in effect for a year plus. The ones that have been in effect for that length of time are generally the larger employers that have complex programs, diverse geographical locations, sub-groups of employees, etc. By the time you get the number of breakdowns that are needed to do the analysis, you've got a lot of paper on your hands. One of the issues that I think we have to deal with is to find a way to be able to do that type of analysis in some controlled fashion. We don't really have the accounting systems thought through to do that, much less the actuarial techniques that you're talking about.

DR. WILLIAM HSIAO*: I'd like to make a few comments on PPO's and also pose a question. The idea of PPO's really came about almost twenty years ago by the Commission on Medical Care Costs. The idea is really for the insurance companies to select low cost providers, hospitals and physicians, group them together, and offer low health insurance premiums to consumers, providing they get their services from this group of low-cost providers. Theoretically, that means that you will have set up the competitive forces between the low cost providers versus the high cost providers. What I have observed in practice is that the insurance companies negotiate with some providers and get a discount, rather than picking out the low cost providers which already exist. One plan out in the East Coast sponsored by a large eastern mutual insurance company, which shall remain nameless, found that, yes, they can get the discounts from the providers but then they also observe an increase in utilization. This is because the providers, let's say the physicians, may have some income in mind, and if they're going to give you a discount they may make it up on utilization. Thus, this approach and its result is contrary to the concept and goals of a PPO. This leads to my question. Why won't the insurance companies try to identify the low cost providers, negotiate with them into some kind of a network and thereby provide health insurance to the consumer at lower premium levels?

MR. ETHINGTON: One of the reasons the carriers haven't done as you've suggested is that they don't have enough people in any particular area to be effective negotiators. We might be successful in Butte, Montana, but I don't think we'd have alot of clout in the San Francisco Bay Area, for example, even though we insure a number of clients in the Bay Area that are pretty large. Also, a big effort is required to get one of these things up and running, and there is a question of how much pay-off there would be. It definitely would be public-spirited work without any expectation for a pay-off with regard to the savings on any particular plan. The Metropolitan is currently involved with the California Health Network in the Bay Area. I believe the arrangement includes hospitals which are in the Bay Area, and which have a reputation of being good hospitals. However, we also know that those hospitals tend to have higher unit costs than some other hospitals. Whether we will see lower costs overall is still an unanswered question.

*Dr. Hsiao, not a member of the Society, is a Professor at Harvard University.

MR. HALL: I essentially agree with both you and Dale, Dr. Hsiao. The insurance industry is moving in the direction of PPO's, but it is complex and we really don't have a ready-made set of signals to follow. Separating the low cost providers from the high cost providers is not an easy process, but it is an evolutionary process. I think there is a good deal of effort going on within the insurance industry to try and move in this direction. We may never succeed but the efforts are moving forward, primarily because of the legislation in California.

MR. CHARLES F. LARIMER: Blue Cross/Blue Shield of Illinois is giving hospital data to employers in such a way that employers can use it to reduce their costs. In the Medical Services Advisory Program that has been set up with Zenith, reports are supplied to Zenith that show by hospital, by age band, and by diagnosis what the average cost per case, average per diem, and average length of stay are, along with other useful data, such as length of stay by admission day of the week.

Prior to a hospital admission, the Zenith employees are to meet with the advisor. Besides telling them where they can get second opinions on surgery, the advisor tells them at which hospital they can have their specific service performed most cheaply.

The Zenith insurance plan was recently changed to 100% of the first $2,000, 80% thereafter with a $1,000 out-of-pocket maximum. One of the messages that Zenith has included in its internal promotion of the concept is that by meeting with the advisor, most hospital stays can be kept under the $2,000 level with no cost to the employee.

The program began on January 1, 1983, with estimated savings to Zenith around 5% since then. It is expected to eventually get savings of around 10% or more.

MR. ETHINGTON: I've seen a couple of arrangements similar to the one you've just discussed. They are a little different in that it is a medical care facility that approaches a customer with the promise of a special deal if the customer sends its employees to that facility. We feel it is quite alright for the customers to enter into these types of arrangements, but as a carrier we have not. At least at this point in time, we don't want to be involved in that kind of advisory role.

MR. JAMES M. MCCREADY: My first question is, will PPO's create a cost-shifting situation? The more prominent companies are likely to be more able to create PPO arrangements and they will get discounts. However, the hospitals still have costs to cover. Thus, those companies that don't get a discount will take the extra costs.

Also, I am aware of at least one organization in the Cleveland area that offers utilization statistics, which provide data for comparative analysis of low cost hospitals and physicians. The cost for these services is somewhat nominal. They are used more by the larger employers than by insurance companies. This is a possible way to analyze and control utilization. Could you comment?

MR. HALL: I will make some comments on your first question. I suspect that we really do have the potential here for some significant cost shifting. It is much too early to know what the end result will be, but the objective is not to produce simply a lower unit cost arrangement but really to impact on utilization levels and quality levels. If the unit cost is high but the utilization is relatively low, there may actually be a net savings in dollars. This scenario may avoid cost shifting.

However, I am suspicious that there could be some significant cost shifting, since many employers have indicated a very strong preference for their insurance company to structure an arrangement which will provide a discount payment when their employees incur medical expenses. With that kind of pressure, I would have to say the potential really is there for cost shifting. It's way too early to know how it's going to sort out.

MR. ETHINGTON: I agree that there is real potential there, but I would also like to point out that the MediCal situation that I described earlier should not produce cost shifting. MediCal selected certain hospitals, so as long as employees go to non-MediCal hospitals, there won't be any MediCal cost shift. However, in the long run, that may create a two-tier hospital program which, I am sure, is not what was intended when this program was adopted. I think it's too early to tell.

In response to your second comment, the Metropolitan offers something called Corporate Health Strategies, which provides utilization analysis by diagnosis, by hospital and by physician. This analysis may uncover patterns of practice that should be changed and, in fact, we have made a commitment as a company to have our medical staff and other contract physicians go into the communities to change those practices. If, for example, there is a physician that is not practicing properly, our medical staff will actually go and talk to the physician, go to the community, go to the local Medical Association and show them the statistics. It is hoped that these techniques will achieve the desired changes in medical practice.

Another technique being used is Hospital Admission Review Plans, which were set up under Social Security; there are also some which were created by private organizations. They monitor hospital admissions on an ongoing basis. The real value of these plans is their sentinel affect: if people know that somebody's watching them, they will clean up their practice a little bit. The types of organizations, like the one in the Cleveland area which you referred to, seem to know alot more than actuaries. They do have alot of utilization statistics, by diagnosis, by area and so on. Often times they can tell you alot more about what's happening on some of these medical care plans than the actuary who prices them can tell you.

MR. MCCREADY: Do you think these organizations and their analyses will have a long term impact?

MR. ETHINGTON: I think the results will be mostly changes in practices over time. For example, if a particular doctor normally prescribes a 10-day hospital stay for a certain condition, and it is brought to his attention that the normal hospital stay is 4 days, he may change his practice. What you should look for is abusive situations, especially the subtle ones. This is where the data gathering and analysis services can be of great value - they can point to the areas where you can change the practice. This will save money for the employer, next year, and for years after that. It will even save money for those employers who don't use the analysis services of these organizations, because the changes in the patterns of medical care will benefit the entire community.

MR. DOUGLAS W. ANDREWS: I have a question for Mr. Hall. My company deals only in Canada, and we don't see very much activity in flexible benefits. You mentioned five different types of flexible benefits arrangements. Could you just give a brief description of each of those arrangements?

MR. HALL: I described the "core plus" arrangement pretty well a few moments ago.

Under the "modular" approach, there are typically several different modules for the employee to choose from. Each module is a complete benefit package in itself; it's as complete as the employer wants to make it. It generally would have at least a specified life insurance schedule, a specified medical plan, and possibly a disability plan. The employee can choose only the entire module; he can't pick and choose benefits within the modules.

The "high/low medical option" concept has been around for quite some time. Under this arrangement, the employee may choose either a very modest scale of benefits, or a relatively rich plan.

The "mix and match", or "trade-off", concept is generally used where an employer starts with a specific program that he thinks his employees are generally satisfied with, but he wants to expand it and so offers choices away from that. Add-on benefits would be made available; conversely, employees can obtain credits by dropping certain elements within the existing program.

The term "cafeteria", or "free choice", refers the wide-open program such as the American Can and Pepsico plans. The employee can choose virtually anything he or she wants; there's a wide range of choices.

MR. JOHN M. BERTKO: I wonder if the panel would care to comment on the unresolved tax issues surrounding flexible benefits, and the lack of the IRS giving any formal approval on these programs.

MR. HALL: I don't think we're going to see regulations in the immediate future because the Service generally takes a long time to develop regulations. There has been a certain amount of pressure from the ACLI, but I just don't think we're going to see anything in the near future.

In any case, the nature of the income tax benefits and the attractiveness of flexible benefits to a number of employers are such that some employers are going to go ahead with these programs anyway. They feel that the law is reasonably clear without regulations, and structure their programs in a reasonable way so that the programs clearly aren't abusive and clearly take into account the discrimination issues that the Internal Revenue Service is generally concerned about. Most employers who are agressive in this sense of wanting to go ahead and proceed with these programs feel that they have a reasonable chance that their program will stand the scrutiny of the Service, either before or after regulations come out. Of course, there's always the hope that if they do drift a little bit away from what final regulations might be, that somehow they would be protected by grandfather clause provisions.

MR. ROY GOLDMAN: We have spent alot of time at this session talking about cost containment. I am aware of at least three bills that have been passed or are pending. One bill was introduced in the State of Illinois and is in Committee; the bill basically says that you can't get a rate increase unless you are instituting cost containment measures. West Virginia has asked for an annual review of what cost containment measures your company has taken. Florida has asked for the same thing, and has introduced a bill requiring mandatory second opinion, 80% coinsurance, and a $500 deductible. Alot of us here are with companies that are working on PPO's, but it seems to me that although Blue Cross has gotten a discount from hospitals for many years, I don't think their claim costs are any lower than those of the private insurers. The government, through Medicare, has had lower hospital and physician rates than any private insurance carrier, but claims costs have continued to increase rapidly.

This leads me to my questions. The first is, is the insurance industry now being asked to do what the government was unable to do? The second is, is it realistic to think that any one insurance company can make much of an impact? It's possible for an insurer to be able to set up a type of PPO in one small area and be able to give its customer employers in that area a break. But can private insurers really have any affect on health care utilization in this country?

MR. HALL: I don't think anybody really knows the answer to that. It's a wide open question, Roy. Certainly it would be difficult for one insurance company to make a significant impact. But I think we're all under pressure. I know that we've given a good deal of thought to these areas, and we are continuing to try and develop processes that will impact on the level of claims under group insurance programs. Whether we actually can or will is just not clear.

I'm a little puzzled by the direction that you indicated a number of states are taking. I can understand when a state passes legislation that requires a second surgical opinion benefit, which is specific enough to enable you to modify your contract and set up claim administration to follow the mandate. I'm puzzled when you say that one of the states required "some type of cost containment program". To me, that's pretty vague. One man's cost containment is another man's extra benefit. The question of whether even second surgical opinions actually save money is not very clear yet.

MR. LARIMER: Blue Cross/Blue Shield of Illinois was subject to the arrangement in the State of Illinois mentioned by Roy Goldman. It affected our direct pay (individual) and community rated products prior to becoming a mutual company late in 1982. The Illinois Department of Insurance would, by whatever means, judge our cost containment efforts and then apply a corresponding cost containment factor, such as 80%, to the actuarially justified requested rate increase.

DR. HSIAO: I would like to respond to Mr. Goldman's question. I don't believe that the government is trying to get the insurance industry to do what the government cannot do. The government has recognized that regulation doesn't always work very effectively. What they're trying to do is pressure the private insurance industry to try different things that will set up competitive forces in the marketplace. If one insurer encourages second surgical opinion benefits and the result is reduced

costs for its customers, that insurer will get more customers. This will force other insurance companies to adopt the same policy, and thus there will be a market force, not a regulatory force, exerting pressure on the providers. This is the government's alternative strategy.