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GROUP LIFE AND HEALTH INSURANCE

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1. External changes in market characteristics and needs - due to such factors as regulation, demographics, business conditions, health care costs, as they apply to the following market segments
   - Small employers
   - Large employers
   - Associations
   - Other

2. Strategies to respond to market conditions in each segment
   - Product - e.g., new products, unbundling of services, underwriting strategies
   - Distribution system
   - Costs - e.g., application of new technology

MR. BARRY L. SHEMIN: Our topic is group life and health insurance. I will start by describing the external forces affecting the business. Then Paul Fleischacker will elaborate on some of these forces and describe strat- egies employers and insurers can follow, after which we'll pause for dis- cussion. Finally, Jerry Winkelstein will cover the small employer market and discuss his company's strategy in that market, and we'll have further discussion.

I've sorted the external forces that affect the group insurance marketplace into six different categories. The first five are economic, regulatory, competitive, technological and demographic and are general kinds of forces. The sixth is health care and is one that has a particular effect on the group insurance market.

What I'm going to do now is go through each of these forces with you and describe how I think it is affecting the marketplace.

1. Economic Forces

The first is economic forces, and here I'd like to start by talking about inflation, which you may think of as yesterday's problem, but it might turn out to be tomorrow's as well.

A. Inflation - The high general rates of inflation of the recent past not only make our premiums grow, but they also increase most of the other types of costs our employer customers incur. Depending on the ability of a particular employer to increase prices, the result has often been a squeeze on profits. That squeeze on profits causes an employer to look for ways to reduce his costs.

Because benefits have been one of the most rapidly increasing elements of costs, employers have been looking particularly hard for ways to control their benefit costs, just as they attempt to control the costs of other goods and services they buy. One way they try to exert this control is by resisting attempts to improve benefits. That's made it more difficult for insurers to attract more business from existing customers.

In fact, many employers have extended this philosophy to actually trying to implement benefit take-backs. Sometimes this is done unilaterally, but in some very visible situations, it has actually been an outcome of the collective bargaining process. Although benefit take-backs would normally mean a smaller amount of business for an insurer, they can also create opportunities for new business as well. An example is where a new coverage such as dental, vision care, or legal is added in replacement for a benefit reduction under the health insurance plan.

Another effect of inflation has been to lead employers to demand an unbundling of the services that relate to their benefit plans. The high interest rates which accompany inflation have been one of the motivations for going in this direction, as employers have moved towards self-funding their plans in order to gain cash flow advantages or higher interest earnings. Another advantage of unbundling services is that the employer can try to control the cost of each service separately rather than having them all combined in a single package.

B. General business conditions - General business conditions is the second topic under the heading of economic issues. These days that's a negative term reflecting the stagnation of the economy over the last few years.

A stagnating economy affects us in a number of ways. First, we have high rates of unemployment. Not only does that reduce the number of employees covered under group insurance plans, but it also raises the per capita cost for employees who remain covered, as the younger employees are the first to be laid off under seniority systems. Unless premium rates anticipate this, it results in losses for insurers.

We've seen an increase in merger and acquisition activity. That creates both opportunities and risks, depending largely on whether you're the insurer of the acquirer or the acquiree. But beyond that it leads to a sense of general turmoil in the marketplace as increasing numbers of employers switch carriers.

Recessionary pressures also lead to an increase in changes of carrier, especially when a deficit has occurred and the inforce carrier would like to get it back. The switch to self-funding has also been spurred by recessionary conditions because of the one-time boost to cash flow and earnings that comes from reserveless self-insured arrangements.

Price concessions are another outgrowth of recession as employers look around for lower premiums, retentions or administrative fees. The employer's profit squeeze gets passed on to the insurer.

And we've seen an upsurge of business failures. When these occur, the insurer is often in a position of having to pay claims without being able to collect premiums. At best, it's in a bad public relations situation having to deny benefit payments to employees. Under minimum premium arrangements it may be responsible for picking up claim liabilities in the event of employer insolvency. And in all of these situations the need to respond instantly ties up large amounts of time that could be directed toward more positive ends.

2. Legislative/Regulatory Forces

A. State - At the state level the most important issue is that of mandated benefits. Here we're talking about the laws covering insurance policies in various states requiring that certain services be covered, certain kinds of providers be eligible for reimbursement, and even in some cases the relative level of reimbursement.

It's a significant problem coping not only with the state-to-state differences in these mandated benefits, but also with the changes that are constantly occurring in these provisions as state legislatures decide what a good idea it would be to have this or that benefit or service provided for all its residents. There is no doubt that this has been a significant force towards self-funding of health insurance plans which the Employee Retirement Income Security Act (ERISA) preempts the states from regulating.

Another effect of state regulation is the existence of barriers to new products and services. These barriers always seem to have a stronger effect on insurance companies than they do on non-insurance providers of similar services. For example, group legal insurance can't be provided in every state and a substantial proportion of the existing group legal benefits are administered by non-insurance legal services corporations.

The use of group products in mass marketing programs is another example of a situation where state laws may restrict new kinds of products.

B. Federal - On the federal level we've got an interesting collection of current issues. A couple of these relate to Medicare.

Last year we saw the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) which provided that employees age 65 and over could choose to have their employer plan provide primary coverage, with Medicare becoming a secondary payor. This revision has generated considerable amounts of administrative activity and will also be increasing costs under employer plans. Although the cost increases will be modest on the average, there may be concentrations of employers or industries that will be particularly hard hit and insurers will need to be alert to be sure that premium rate levels anticipate this.

More recently, the social security reform legislation (just signed into law) changes the hospital payment system for Medicare to the diagnostic related group system now being used in New Jersey. Although this may create some healthy incentives for hospital cost reduction, an equally likely effect is increased amounts of cost shifting to the private sector.

Federal tax policy also has an impact on the group insurance business. Taxability of benefit costs has effects in several areas. Outdated imputed income tables for group life insurance have encouraged shifts to individual coverage. Group legal costs are deductible by employers and not taxable to employees, and that's likely to encourage the spread of this kind of coverage when economic conditions improve. By contrast, group auto costs would not be deductible or would be taxable to employees which is likely to present a significant obstacle to the spread of that benefit.

Of course, most of the recent activity has involved the tax treatment of health insurance plans. A provision of TEFRA increased the threshold for individual income tax deductibility of medical costs and reduced the deductibility of health insurance premiums. Those changes should theoretically lead to employee demand for more comprehensive health coverage.

In just the opposite direction would be the tax-cap legislation now being considered. It would limit the health insurance costs that could be fully deducted by the employer and also non-taxable to the employee. If these tax-cap proposals are written into law, they will have a very significant impact on the health insurance business. It's impossible to predict what that impact will be. It will depend on the specific technical design of the cap.

3. COMPETITION

Let's start by considering the traditional fully insured life and health product that insurers have been selling to employee benefit plans for a long time. You pay your premium and your employees collect the benefits.

I think a good case can be made that this traditional product is in what product life cycle theorists call the "decaying maturity stage". That's the stage where real product revenues begin to decline as newer products emerge that are more attractive alternatives. Marketing theorists will tell you that the decaying maturity stage is characterized by excess capacity, intense price competition and declining profit margins.

I think those characteristics are ones which seem to apply to the traditional group insurance product. Excess capacity is difficult to prove objectively, but it does seem that for every company that goes out of the group insurance business there are two or three companies deciding to get into it. And the product with which they typically enter is the traditional fully insured group insurance policy. As to the existence of price competition and eroding profit margins, that should be self-evident.

The product life cycle theory would predict that eroding profit margins would eventually push many companies out of this product line and result in a smaller number of better entrenched companies dominating the business. As company planners, it behooves you to decide whether you think you can be one of those remaining competitors in that product line. If not, you probably should redirect your efforts early enough to avoid the worst of the battle.

Although the traditional insured product may not be a good source of growth or profits, that doesn't mean there aren't good markets for group insurance products and services. Directions one can go here include:

- Unbundling your services and looking for particular market niches where those services are in demand or where you can provide a superior service in terms of either quality or cost.

- Being an early entrant into new areas, which could include new forms of benefits or new distribution channels or entering new markets.

In many of these new markets you can expect to run into new kinds of competitors - third party administrators, employee benefit consultants, software companies and various firms associated with the health care industry.

I'd like to comment on competition between insurance companies and benefits consultants. Consultants have recently been increasing their service activities for health plans, especially self-insured ones. It's tempting to draw an analogy between where the group insurance business is today and where the pension business was twenty years ago. Since that time we've seen consulting firms take over many of the pension services that insurance companies had traditionally provided, with insurers now attempting to concentrate on providing investment services.

The analogy for group insurance plans would be that consultants will eventually take over benefit design, cost containment and affiliated services while insurers end up concentrating on claim processing. While that's certainly a possibility, I'm not sure the analogy is a terribly good one. For example, many of the consulting-type services that employers are demanding tend to require access to and knowledge of claim data. And it may be that because of their possession of this data insurers will have an edge in using it to provide other services to employers.

4. TECHNOLOGY

The first thing to mention here is the electronic bill receipt process. This process will allow hospitals and other providers of medical services to submit claim information electronically. For insurance carriers, the recipient of this information will be the National Electronic Information Corporation (NEIC). This is a clearinghouse which was formed by eleven large insurance companies and now has over twenty participating carriers. NEIC will take the electronic claim information received from providers and transmit it to the appropriate carrier for processing of the claim.

The state of technology here is that we are not very far away from the time when a claim can be handled completely electronically. It will go from the provider, to NEIC, to the carrier. The carrier's claim processing system will be capable of automatic adjudication without the intervention of a claim approver. From that point the emerging integrated financial services companies of the future will undoubtedly be able to debit the account of the employer or insurer at its own banking subsidiary and use electronic funds transfer to credit the payment to the account of the employee or the provider. The employee will of course check on the arrival of the promised claim payment by calling up the information on his home terminal.

Data collection is another area where technology is having an important effect. As health care costs increase, employers are showing an increasing interest in understanding their costs. They are asking for all kinds of data related to claim experience. They want analyses of that data including suggestions based on the data, of ways to contain costs. Those carriers that have systems to make this data available in a form that employers can use will have a strong competitive advantage in the future.

5. DEMOGRAPHIC FORCES

The next major category is demographic forces. It's one that actuaries always like to talk about and which probably won't present any major surprises to this group.

A. Aging population - The aging of the population has been a popular topic of discussion in many contexts, and it has an impact on benefit plans, like everything else. One impact arises simply from the fact that the per capita costs of group life and health insurance plans increase with age. That alone will cause benefits costs to continue to increase faster than the working population.

   Another likely effect relates to future labor force participation. With the likelihood of cutbacks in social security and with an increasing proportion of the population approaching the age at which it has become popular to retire, it's very likely that retirement ages will start to rise. Since employer plans will be the primary payers for those over 65 who are working, an increasing portion of the costs for the growing over-65 population will be borne by employers. The strong likelihood that mandatory retirement at any age will be outlawed in the not too distant future will further accentuate this trend.

B. Two-worker families - The increasing number of two-worker families also has an impact on benefit plans. Coordination of benefit provisions result essentially in complete reimbursement of a two-worker family's health costs. That removes much of the employee's financial incentive to control health care expenditures, and unless the coordination of benefits provision is changed, it will end up frustrating the efforts of many employers to contain costs by increasing deductibles and coinsurance provisions.

The fact that they may be covered under two health insurance plans is not lost on the two-worker family either. That's likely to lead to increasing demand for flexible benefits plans. The ability to design, install and administer these plans could provide significant market oppportunities for insurers if ways can be found to avoid the cost increases that frequently result from anti-selection under these plans.

6. HEALTH CARE

This brings me to the category which we are all most interested in - health care. We all know that health care costs are rising at rates which should be unsustainable. But the rates have been unsustainable for years. Medical and hospital costs have out-paced the general consumer price index going back nearly twenty years now. In 1982 the general consumer price index has declined substantially, but health costs are rising at double or triple the general rate. You can debate forever what are the most important reasons behind this long term record of costs increases. I'll just list some reasons for health care cost increases and not try to pinpoint those that have made the biggest contribution.

(1) Insurance coverage is universal. Private coverage for workers has been increasing for years and the passage of Medicare and Medicaid in 1965 covered the poor and the elderly. Widespread coverage increases demand.

(2) Union bargaining has had an effect. Health insurance benefits used to be viewed as relatively inexpensive and unions tended to favor comprehensive first dollar coverage. Salaried plans tended to follow suit.

(3) The laws of supply and demand don't seem to apply to the health care industry. Those who pay the bills don't control demand. In fact, those who send the bills and set the prices probably have more to say about the demand for their services.

(4) Medical technology has pushed up costs. The original cat scanner used to be everyone's favorite example, but we've gone way beyond that. Transplants and mechanical organs will probably be tomorrow's example.

Many of these things are very good from a social point of view, but they also increase costs. And, this is far from a complete list. One could add malpractice insurance premiums, the defensive medicine that goes along with the increasing malpractice litigation, and so on.

Cost shifting is another force which has particular impact on those of us associated with commercial insurers. Government programs clearly do not reimburse hospitals for their full share of costs.

Blue Cross may or may not shift costs to commercial carriers, but they certainly don't absorb an appropriate share of the cost shifted away from government programs. That leaves the commercial carriers to cover the lion's share of the remaining costs. And these charges work their way through to employers and eventually into the costs of the products and services we all buy.

The Health Insurance Association of America (HIAA) most recently estimated that cost shifting to private carriers will rise from $5.8 billion in 1982 to $7.9 billion in 1983. And that doesn't include the shift of Medicare payments to a diagnosis related prospective payment approach starting in 1983.

There have been some strides made to control the rise in hospital costs. Several states have introduced prospective payment programs applying to all payers, New York and Massachusetts being the most recent. And I guess we have to hope that the new Medicare structure will not preclude the implementation of similar programs in other states.

Cost containment is the single most important topic of discussion with most employers these days, certainly the large ones. A recent survey of benefit managers of Fortune 1000 companies identified it as the number one problem in employee benefits. It was number two in 1980, and only number nine as recently as 1978.

Employers are changing their plans to incorporate cost containment features. They're increasing their activities on the local level. They want data to help them identify particular problems and suggest cost containment programs. They want help in designing and implementing these programs.

I think the ability to provide cost containment services to employers is going to be one of the key determinants of insurance company success in the group insurance business. And I might add that I think that the large companies start out with a significant advantage in this arena.

There are sizeable economies of scale in providing these services.

- You need a sophisticated computer system that may require substantial investment to develop.

- You need a sizeable staff at your headquarters and ideally in field locations, to help employers implement these programs on a local level.

- And you need a significant market share in a number of localities to be effective in implementing these programs.

There you have a comprehensive litany of all the forces which create numerous problems for us and maybe even an occasional opportunity. Now, we are going to learn all about how to solve those problems and capitalize on those opportunities from Mr. Paul Fleischacker.

MR. PAUL R. FLEISCHACKER: My presentation will focus on product trends and customer demands in related product strategies for the medium to large employer accounts. However, before discussing these product trends and strategies, let's take a look at the forces affecting insurance suppliers.

- What are the environmental changes affecting you, the insurance supplier? There are the economic and regulatory trends of high interest rates, high unemployment, runaway medical cost, inflation and state and federal legislation.

- From the provider there is the increased competition for providing health care services. There is an oversupply of hospital beds and physicians. There have been signficiant, costly advances in medical technology. And finally there will be alternative delivery systems, health maintenance organizations and preferred provider organizations.

On the other side, because of these influences, the customer is demanding coverage flexibility, more cost sharing, cost containment features, funding flexibility and excellent service. Your competition is responding to these demands with more coverage flexibility, particularly in the areas of cost sharing, cost containment features, cashflow financing, systems expertise and involvement in alternative delivery systems.

Although Barry has thoroughly addressed the economic, regulatory, and provider trends and issues, due to their importance and impact on the customer demand, I want to spend a few minutes redirecting your attention to these factors.

The major economic issues are:

1. Medical cost trends which are affected by:

   a. Inflation rates which are far exceeding the overall Consumer Price Index (CPI) rate.

   b. Cost shifting from Medicare and Medicaid programs, some Blue Cross plans having large differentials, and possibly from some alternative delivery systems, - the health maintenance organizations (hmo's) or preferred provider organizations (ppo's), particularly if the hospital's involvement in the hmo or ppo did not increase its market share.

   c. Utilization increases which have resulted from greater use of services, the leveraging effect of inflation on plans with deductibles and limited to payments and aging.

   d. Provider oversupply. One carrier has estimated that over the last four years the physician supply has increased by 3% but the general population by less than 1%. Will this mean reduced charges because of increased competion? Or increased charges so that the physician can maintain his standard of living? Also, in several parts of the country there are just too many hospital beds.

   e. Advances in medical technology has certainly helped to improve health care service but has also caused increased cost.

2. Interest rates, or cost of money. Interest rates, of course, affect the pricing of your product. More important to the employer, however, is the borrowing rate. As long as the employer can borrow from the insurance company through reserveless type plans at a cost effective rate, there will be a strong demand for reserveless funding arrangements.

3. High unemployment which has resulted in reduced marketshare for many carriers, in reduced employee/union demand for improved benefits or even agreeing to reduced benefits to save jobs, and at least temporarily, in aging of the working population due to the younger employees with less seniority being laid off.

In addition to the economic issues, there are several major regulatory consumer and technological issues which influence the employers and suppliers to react with change.

With TEFRA most of the group insurance industry's reaction has centered on the Medicare provisions. Also of importance are the provisions dealing with the dividend deduction limitations for companies and how these limitations may be reflected in dividends and stabilization reserve strategies. President Reagan's proposal and the Department of Health and Human Services' proposal deal with Medicare reimbursement rates, both of which could result in additional cost shifting. President Reagan's proposal also includes a ceiling on non-taxable health insurance premiums. If this is passed, I can foresee a further push towards increased cost sharing, for example, higher deductibles and an acceleration in growth of other employee benefit programs which are more cost effective. There is also the HIAA proposal which is a counter-proposal to the Department of Health and Human Services' proposal, designed to reduce or eliminate some of the cost shifting. And finally there are the pro-competition bills.

In the area of state regulations, many states have some form of hospital containment programs, the most far reaching being Maryland, New York, Massachusetts, and New Jersey. The state mandated benefits have influenced many employers to self-insure their programs since ERISA preempts state regulations. Business coalitions are also a factor influencing the delivery and cost of medical care. At the latest count, over 100 coalitions exists in the United States.

There is the impact of the system's technology resulting in expanded servicing capabilities and additional competition from third party administrators and software firms. The providers have also affected the marketplace due to the increased competition, oversupply, advances in medical technology and participation in alternative delivery systems.

What are the customer's attitudes towards their group insurance programs? What services do they consider most important? Are they satisfied with the service they are receiving?

In 1982 Towers, Perrin, Forster & Crosby (TPF&C) conducted an employee attitude servey with 94 large midwestern companies. In evaluating the relative importance of various services provided by their medical and dental carriers, survey participants rated the claim payment service as the single most important service. Cost considerations while clearly significant are considered less important than claims payment services. Good management reports rank a close third.

The ten most important items were:

(1) accuracy, timeliness and responsiveness of claim examiners

(2) responsiveness to problems

(3) quality of account representative

(4) overall cost of services

(5) funding flexibility

(6) reasonableness in negotiating

(7) accuracy of reasonable and customary levels

(8) financial and utilization reports

(9) cost containment expertise

(10) accuracy of claim projections

Overall, survey participants were relatively satisfied with the services provided by the carriers. There were no significant differences in overall satisfaction levels among major carriers. There is, however, a significant difference between the importance level and satisfaction level on the claim payment services and management reports.

As to the participant's satisfaction level, they indicated a low level of satisfaction with the health care utilization reports they receive and with carriers' ad hoc reporting capabilities. Approximately half of all survey participants would like to receive more extensive utilization data for their medical plans. The participants also indicated a relatively low level of satisfaction with the cost containment expertise of the carrier.

So far I have discussed the trends in the environment and have pointed out various economic, regulatory, and technological trends. I have also discussed the customer attitudes - what he expects from his carrier. Very simply the employer's costs are going up and he is looking for an effective way of controlling those costs. The employer is looking for products and services which can solve his problem and it is up to the supplier to respond to those product demands. The market-driven company, one which is sensitive to the needs of the marketplace, will succeed or fail as a result of satisfying the consumer; but the company faces a unique challenge. It must provide not just quality or competitive products and services, but also a package of products and services which is demanded by its chosen markets.

The proper approach is to understand the characteristics of the chosen markets. You must define target markets, interpret the target market demand characteristics, convert these demand characteristics to product and servicing requirements and develop your product and service strategy. Our definition of product includes the entire package - the coverages, the financing and the service.

Let's look at coverage trends first. In the medium and large accounts we have observed a major shift to cost sharing or transfer-type plans such as comprehensive, medical and the addition of many cost containment features. The Conference Board Reports on Profile Employee Benefits shows that from 1974 to 1981, there has been a dramatic shift in comprehensive medical coverage both with office employees and non-office employees. In total, the number of comprehensive plans increased by over 50% from 1974 to 1981. For office employees it increased from 31% in 1974 to 45% in 1981 and for non-office employees, from 21% in 1974 to 36% in 1981. More and more consideration is being given by the employer to higher deductibles and higher co-insurance provisions. The comprehensive medical plan is now being designed to make employees think about what they spend. They are being redesigned to encourage more frugality and discretion in their use.

In 1982, TPF&C conducted three employer surveys which dealt in part with coverage trends. In the first survey, TPF&C contacted 40 major companies to obtain information on medical plan changes made during the past two years. The survey indicated that

- 54% of the companies either had switched from a base medical plan with superimposed major medical to a comprehensive major medical plan or are now offering a comprehensive major medical plan as an option in a multiple choice or cafeteria type program.

- Of the remaining companies, 41% increased their deductible and 27% decreased the co-insurance rate.

The second survey was a survey of TPF&C's Employee Information Center member companies regarding medical cost containment measures adopted during the last three years. Of the 390 member companies 272 responded to the questionnaire. The results indicated:

- 22% have increased the deductibles and another 37% are contemplating such a change

- Approximately 18% have reduced the co-insurance rate and/or increased the stop loss point, that is, the level beyond which the plan would pay 100%.

The third survey was a group insurance survey which I mentioned previously. It indicated that 41% of the companies have increased or, in the next year are planning to increase the deductible. Also, 33% of the companies have or will be decreasing the co-insurance rate.

Besides the trends in cost sharing, what are the major cost containment benefit design changes that employees are making? The results from the TPF&C group insurance survey indicated that the major cost containment design changes implemented or planned are:

- a second surgical opinion
- pre-admission testing
- out-patient surgery
- home health care
- hospices
- generic drugs

In TPF&C's survey of medical plan changes in 40 companies, the most prevalent cost containment changes were:

- ambulatory surgery
- second surgical opinion
- home health care
- hospices
- extended care
- pre-admission testing
- alcohol and drug rehabilitation

The second part of the product that must be delivered to the customer is the funding arrangement. We have observed the following major financing trends for medium and large accounts:

- retrospective rating arrangements
- delayed premium arrangements of 90 or 120 days, often coupled with retrospective rating arrangements
- administrative services contracts often coupled with stop loss insurance, and
- minimum premium plans, usually the no reserve type.

Virtually all large accounts are, in effect, self-funded through one of the above arrangements. The type of financing arrangements required for this market can best be characterized as cashflow management. The employer wants to use your money or retain the use of his money at a very favorable rate of interest.

In the medium size account market there are serveral different funding arrangements. The most prevalent is still the traditional insured product with some level of experience rating. But there has been significant growth in administrative services contracts with insurance companies and third party administrators coupled with stop loss insurance and minimum premium plans.

Let's take a look at actual trends. Based on the results shown on the HIAA Health Insurance Fact Book plus information provided by the HIAA, group benefits paid by insurance companies under administrative services contracts and minimum premium plans increased from 9.3% of total benefits paid in 1975 to 37% in 1981. There were very large increases in 1976, 1977, and 1980. Follow this scenario. In 1974, the wage/price controls were lifted. The insurance industry missed significantly the trend projections for late 1974 and 1975. As a result, the industry requested significant rate increases in late 1975 and 1976 and the employers reacted by switching to alternative funding arrangements. Likewise, voluntary price controls, high inflation and high interest rates are the likely causes for the large 1980 increase.

The TPF&C's group insurance survey indicated 81% of the participants have either minimum premium plans or are self-insured. Of the 19% insured, I would guess most of these plans have some form of retrospective rating agreement or a delayed premium arrangement and are, in effect, self-funded. Approximately 50% of the participants had made recent changes in their funding arrangement or were planning to do so in the near future. Likewise in the Conference Board Report, the number of self-insured or partially self-insured plans increased from 7% of the total in 1974 to 24% in 1981.

Finally, we have the survey performed by the National Association of Employers for Health Care Alternatives. This was a survey of 500 of the Fortune top 1500. The self-funded type of contracts represented 50% of the total in 1979. In 1981, the percentage was 69%, almost a 40% increase in two years.

The third element of the product that must be delivered to the customer is service. As indicated previously when discussing employer attitudes, the most important service requirement is accurate and timely claim service. Also, as with coverage changes, we have observed significant cost containment activity in this area.

Finally, we have observed major competitive commitment in new systems and systems enhancements. Barry mentioned the NEIC which now has twenty participating carriers. Also, individual carriers have made substantial investments in systems - for example, John Hancock's Hanstar system and Prudential's Pru Trac. Also, some third party administrators are attempting to capitalize on the cost containment fever with sophisticated computer software specifically designed to meet the demands of the marketplace.

In the service area, what are the major cost containment trends? TPF&C's group insurance survey indicated the major cost containment activities implemented or planned were:

- hospital audits and improved employee communications
- inside claim audits and length of stay analysis and admission rate analysis
- review of surgical frequencies.
- improvement in coordination of benefits aministration.

Based on our surveys and client studies, insurance carriers must make improvements in many service areas if they are to be a competitive factor in the medium and particularly the large account markets. The major needed improvements include:

- The ability to unbundle and properly price service so that the employer can select the services and develop an administrative program which is most cost effective for him.
- Improved management information reports including utilization analysis and norm comparison. Too often, we see reports provided to the employer which show detailed utilization data but no norms for comparison so the employer does not know whether or not his plan's experience is good, bad or indifferent. Also, there is a lack of management information reports which monitor the impact of cost containment activity. The employers are going to want to know the cost effectiveness of the changes that have been made in their programs.
- Stricter claims admistration particularly in maintaining and administering the usual, customary and reasonable fee profiles and in administering the coordination of benefits provision
- Improved employee communications, particularly in educating the employees on cost containment and what they can do to help.

How can all this be translated into product strategy? What is the required market response by you the insurance supplier? In three words it is meet customer demands. Meet the demands for the markets you want to serve in:

- Product design flexibility particularly for incorporating cost sharing and cost containment features.
- Pricing and financial flexibility.
- Accurate and prompt claim services and effective claims controls.

- Administrating services, prompt and informative reports on premiums, retentions, claims, reserves, cost containment activity, etc.

- And finally, but not least, a distribution network that is geared to operate effectively in your tartgeted markets.

In conclusion, for the medium and larger markets, I agree with Barry's observation of the decaying maturity stage for the traditional wholly insured products. Although there are still some niches in which these products can be used, by and large, employers are demanding flexibility and sophistication in coverages, financing and servicing.

As John F. Kennedy stated: "Change is the law of life. And those who look only to the past or to the present are certain to miss the future."

MR. RICHARD G. MURDOCK: There were some comments about the NEIC and the electronic transfer. We have been pondering this recently and I would like the observation of one or more members of the panel on the advisability of this. It seems that once this electronic transfer takes place you lose some control over your checking mechanism over what the hospital billing facility is like. We talked about the needs to become more familiar with hospital bills to challenge improper charges and yet the advent of the NEIC and similar arrangements would tend to undermine the ability of the average employee consumer to do that.

MR. SHEMIN: There is some danger that automation will go against cost containment. Not only would it include electronic bill receipt but also automatic claim processing. However, I am told that the data that will be transmitted to NEIC will include more detail than is often provided on hospital claim forms, including procedure codes which if done properly should enable an insurer to apply statistical techniques more accurately than one can now do. I do share your concern to some extent.

MR. FRANCIS G. MOREWOOD: There was a meeting last week in New York City and one section was quite heavily devoted to the question of cost containment. The consensus of opinion seemed to be that most efforts at cost containment have not been successful and things like second opinion surgery didn't really result in reduced overall costs. An item of particular interest was one technique that was suggested as a good method of cost containment. That was having professionals on your staff who could take an employee through each step of his operation and treatment and scrutinize the next step that was going to be taken, the way it was going to be done, how much it was going to cost, and help him make his choices as he went along. Now I find that incompatible with the concept of totally computerized claim service that does all the adjudication that is in the machine. I don't see how you can marry the two.

MR. MICHAEL J. KINZER: I think you can have the two, only it's a little impersonalized. Through the NEIC you would have this tremendous data base which can produce reports showing your operation and what the average amount for a similar operation is in your city, state and nationwide.

If you are more than 10% or 20% or a specified amount over the average, maybe you should question the charge. But it takes a little more management control on our claims people and our claims managers. People like us probably build those parameters into the software which NEIC would have.

MR. SHEMIN: I think that is a valid comment. You can also visualize certain pre-certification programs, for example, working more effectively if the base of data on which norms can be derived is more comprehensive and more detailed. I agree if nothing happens then data ends up flowing in one end and electronic funds transfer out the other. It is hard to contain costs that way.

MR. RAYMOND F. MCCASKEY: To a certain extent we are already doing both of those things in Illinois. We have internal hookups with many of the hospitals, especially in the metropolitan area of Chicago. We also have a program with one of our major corporate employers where they utilize a doctor who outlines proposed procedures for each of the employees who is having non-emergency hospitalizations. In addition, each employee has a little card with six questions to ask her physician in order to obtain coverage. They bring back the answers to the six questions and the medical director at the company then goes through them. If he finds anything that is out of line (and they key here is having data available as to what costs are by diagnosis and by institution in the area), or can suggest a less expensive alternative, he will contact the doctor and negotiate perhaps a different course of treatment or a different hospital where the same thing can be provided less expensively. The key is that this happens before the hospitalization takes place. The electronic process for the payment of the claim or the transfer of the funds takes place after. The two really are not incompatible - they happen in two different phases of the whole cycle.

MR. ROBERT J. DYMOWSKI: Paul, you talked about traditional cost containment activities and they generally focused on the types of things we have just been talking about - claim reduction, co-insurance, deductibles and so on. You didn't mention much about longer term programs, such as wellness programs or lifestyle change programs. Have you seen very much of that?

MR. FLEISCHACKER: I personally have not seen too much activity in that area. I know a few of our benefit consultants have worked with some major corporations on establishing the wellness type programs. Most of the studies that I have seen are largely an unmeasured type thing as to the effectiveness of those programs, but a lot of employers are sold on the concepts.

MR. SHEMIN: Now we are going to hear from Jerry Winkelstein. In the last four years, both as a consulting actuary and in his current position with John Alden Life, Jerry has devoted himself almost exclusively to the problems of managing mini-group life and health business and he believes that his line of business can be one of the most profitable group insurance lines.

MR. JEROME WINKELSTEIN: John Alden Life is a unique company with a unique insurance strategy and my talk will be concerned with describing the strategy. John Alden Life is based in Miami, Florida and is a medium size stock company with about a billion dollars in assets. It has an A Best rating and it has shown a Generally Accepted Accounting Principles (GAAP) profit on its mini-group line in each of the thirteen years between 1969 and 1981. We entered the mini-group in 1967. Unfortunately, in 1982 John Alden did incur a modest GAAP loss of approximately $300,000. However, due to corrective actions taken in early 1983, we expect to return to profitability in the calendar year 1983. I will describe these actions later.

John Alden Life is primarily a developer and wholesaler of specialty life insurance products distributed through a variety of means including independent agents (which includes the captive agents of companies we enter into joint company-to-company ventures with), stockbrokers and financial institutions. Since our major distribution network is through the independent agent, our product must be a specialty product in order not to compete with his main product, which is usually whole life or annual renewable term. Mini-group is distributed solely through independent agents. They are contacted through a system of tele-marketing. We have 40 or so regional offices located throughout the United States.

Lately, we have been trying to expand our marketing through joint company-to-company ventures. In this regard, we seek out companies that have so-called captive agency forces. These are forces which can penetrate under normal arrangements. We give their agents, whose incomes are down because of whole life production being down, a new product to sell and, in turn, they expand our marketing to areas where we would not ordinarily be able to reach.

The major reason for our group insurance success is due to the fundamental management edicts set down by John Alden to management. These edicts can be summarized as follows: (1) Market only products in which we are specialists and which have the potential of returning a substantial profit. It sounds obvious but a lot of companies don't do this; (2) Position yourself away from competition to increase your return to risk ratio; (3) Maintain control over the products you sell.

We satisfy the first edict which is sell only products in which you are specialists and those which have potential for very high profit, because we only sell five products. We have a captive credit insurance product, which is produced by our sister company, Blazer Financial Services. The second product we sell is single premium deferred annuity. The third product is individual retirement annuities. The fourth product, which is the product I'm responsible for is our mini-group life and health insurance plan which is marketed to groups of one to nine lives. Our average life is 2.8 lives. The fifth product is one which we have recently introduced, Universal Life.

All new products are introduced only after an extensive review by our product planning committee. The product planning committee consists of actuarial, marketing and administrative personnel. We follow a very rigid planning process with many check points to monitor and control the implementation of a brand new product. We have strategic planning sessions in which we develop three and five year strategic plans. I personally don't have that much confidence in the accuracy of either the three year or five year plan, but nevertheless we go through the exercise. If you don't know where you are heading, you have no way of knowing whether you are getting there. All of our plans are continually monitored and updated when necessary.

John Alden Life is a very profit oriented corporation. Only profitable production is tolerated by our senior management. We don't desire production if it is not profitable. To enforce this, a large portion of the salaries of middle and upper management, and this may comprise about 20% or 40% of the individual's salary, is based on profit. Our marketing officers are included in this profit plan. We define profitability in terms of actual versus plan GAAP return on equity, and the plan return on equity is developed in line with our overall strategic plan. We put together monthly GAAP statements monitoring our insurance lines and we continually analyze them. GAAPing mini-group is a somewhat unusual concept, but let me describe a little further how we GAAP it. Our mini-group product has very high first year commissions. We pay 25% first year and 10% renewal to the broker. We also pay our field people on the basis of first year premium only, although whether they keep their job or not depends upon whether their block of business is profitable. We employ a "carrot and stick" philosophy here. Under GAAP, we amortize our first year expenses and only direct expenses are charged to the line. All profit, investment income on past accumulated profits and overhead expenses are thrown into a shareholdes' equity account. This gives us a marginal accounting of each line and this is in line with our strategy to continue to market only products which remain profitable.

The second edict is position yourself away from competition. This is a very basic premise of profitably marketing any good or service. A company can be most profitable when it offers a needed product in an arena where there are few peer competitors. John Alden has embraced the concept that an insurance product, like most other consumer products has a life cycle. The product's profitability will be great when it is first introduced and there are few, if any, competitors. Then the product will reach a mature state as more and more competitors come into the market and the resultant profitability drops. Finally, as the marketplace becomes saturated, the product becomes only marginally profitable and should be either modified or withdrawn.

At the back of our minds when strategic planning decisions are made, is the fact that one option we can always exercise is to use an exit strategy and withdraw from that particular marketplace. We have done that type of thing in the past. For example, we have previously withdrawn from the mass mail order market. We felt we weren't experts in it and it was too competitive. One reason we are able to withdraw from a marketplace

fairly easily is that we don't support a captive agency force. Therefore, there are less vested interests that we have to protect. The mini-group insurance marketplace is very volatile and we constantly see the appearance of what we call "low ball" competitors who stay around for a couple of years and then either go bankrupt or withdraw form the market. However, the competitive situation in mini-group is far less severe than in other group insurance marketplaces. Less competition means that higher profit can be rated for and achieved.

The third major edict followed by John Alden Life is the concept of control. A major reason John Alden is able to exercise a great deal of control over a product is due to our marketing structure. We can withdraw from a product and not have to worry about the negative aspect on a captive sales force. By not selling through large brokerage operations which have many brokers and therefore would control a large portion of our business, we cannot be pressured, ratewise or otherwise, by one large broker threatening to move a large portion of the business. Therefore, our field underwriting and our home office underwriting rules cannot be easily compromised. Another way we exercise control over our independent brokers is through our high commission structure. We tell the brokers, "Yes, we are paying 25% first year with 10% renewal commissions while our competitors are paying 15-10 or level 10, but we want only the cream. If you fool us once, you are not going to get a second chance to fool us." Field underwriting is the most important concept in group insurance and especially in mini-group insurance. The independent broker who brings you the case knows more about that case than you will ever know, even if you looked at it in the Home Office for a year. He has a good idea what is going to happen in that case and if he doesn't level with you, you can and will lose money.

In addition, when a broker finally brings a case to our group representative, our rep negatively sells our tough pre-existing condition exclusion. We have a pre-existing condition exclusion that is six month treatment free, twenty-four months covered under the plan. In fact, if one of our brokers asks, "What is your pre-existing condition exclusion?" a warning bell goes off in our field rep's head and he asks, "Why do you want to know?" and our rep tries to get the true story. If the case is not what we call the cream, our rep will tell the broker to take it to Company XYZ. Many of you may be working for Company XYZ. Company XYZ is the insurer with the weakest acceptance criteria in the area. One of our reps recently told me that he actually gets taken out to dinner rather freqently by the Blue Cross in his area because he was sending so much business to them. The independent brokers love this arrangement and this cements our rep's relationship with the broker because now the broker has two carriers, one for the cream (John Alden) and the one for the rest (Company XYZ).

Finally, we also employ very strong individual health underwriting at the home office level. We will exclude a person. We will waiver a person for a condition or we will rate up a person for a condition. We follow individual health underwriting rules.

The market for mini-group insurance is huge. A study published in 1978 by the Marketing Department to U.S. News and World Report revealed that 86% of the employees of one life group and 61% of the employees in groups with two to nine lives carry no group insurance. That is neither life nor health. Individual health insurance is typically written to a much lower ratio with significantly lower levels of benefits. Therefore, there is definitely a major need in the market for mini-group life and health plans. Another positive aspect of mini-group insurance is the relative ease of adhering to state regulations.

You may notice in my speech, I refer to our product as mini-group. I don't use the term multiple employer trust (MET). MET has become a bad word in the industry. All of our literature now reads "mini-group".

We keep up with state regulations by writing the business through a trust cited in a friendly state and obeying only the regulations of that state whenever possible. This allows us, among other things, to define and rate for only those coverages we wish to provide. For instance, unless we are forced to, we don't offer outpatient mental and nervous coverage, which is a very abused coverage in all group insurance and particularly so in mini-group.

Another advantage of mini-group insurance relative to true group insurance (true group insurance to us is group insurance of ten or more lives) is that from an actuarial standpoint much better experience statistics are available. On the claim side, a mini-group line is much more homogeneous plan-to-plan than is its true group counterpart. Therefore, it is possible to create a more statistically significant data base on the whole block of business. There isn't much variation among the plans offered under a mini-group trust. Furthermore, and more importantly, since mini-group insurance is list-billed, accurate detailed premium exposure data is available. One of the major problems in evaluating the experience under a true group insurance program is the fact that due to simplified billing, accurate exposure data is available for groups only at the beginning and/or the end of the exposure period and sometimes not even then in a good enough format.

Under mini-group insurance, John Alden is able to obtain premium and claim exposure data by age and sex for the following classifications: male employees, female employees, male spouse, female spouse and children. When I talk about the spouse, I am talking about the actual age of the spouse and not just an estimate based on the age of the employee. Since John Alden rates by these demographic parameters, the utilization of such statistics readily translates into the minimum premium rates that are needed for adequacy purposes.

I would like to digress for a minute and describe how we go through a premium rate increase exercise. We put together our experience and develop what we consider minimally adequate rates and then we meet with the marketing department. We determine in what areas and by how much competition will allow us to increase the rates. Our relationship with our marketing department is very unique. Remember that they are under a profit bonus plan also. Basically, we look at our competition and try to

place our rates approximately 5% above the average of our competitors. We don't want to be below and we don't even want to be in the middle. We want to be 5% above and we want to be 5% above not at the beginning of the rate period but in the middle of the rate period. Our sales reps don't mind us being 10 to 12% higher in the beginning. They feel that due to our reputation and the higher commission levels, they can sell this level of rates. Our marketing department wants fat in the rates for two reasons: (1) they receive profit related additional compensation and (2) past favorable claim experience leads to more stable future rates.

As I mentioned earlier, in spite of all these good things we do, we did have a disappointing year in 1982. It is not as bad as some of our competition, but that is small consolation as we're in the insurance business to make a profit. If we don't turn a profit, our senior management will seriously think of closing down the line. We made a couple of major changes in our product effective February 1, 1983 in order to enhance our mini-group profitability in 1983. First we instituted a more exact rating structure. Previously, our rating structure consisted of unisex employee rates and composite dependent rates. Now we have male adult, female adult, and children rate structures. I hope unisex regulation doesn't put us back where we started. This new rate structure has enabled us to penetrate the two person family market and correctly rate for all size groups. Previously it appeared that we had been selected against on family size. We were getting more full families. The second major change we made was due to the fact that previously our only maternity coverage was maternity as any other disability. Again remember that we write only groups with one to nine lives and therefore we are not affected by federal regulations. Certain states have maternity regulations which we do obey, but for the bulk of the country, we don't have to offer maternity and we don't. Right now, for groups under five lives, we either offer no normal maternity or a $500 deductible for maternity. Of course, we have to cover Caesarean sections or other complications. We feel that this change produces two positive effects. One is that it enables us to penetrate the no maternity marketplace which we were not able to do beforehand. The second is that it enabled us to avoid the effects of both maternity anti-selection and subsequent shock claims due to premature births .

The second effect may be more crucial. Of course we would pay for a premature birth claim if it happened, but we should be receiving positive selection by the insured, himself. If an insured wants maternity coverage, he will probably go to a competitor that offers maternity as any other disability coverage. He is not going to come to John Alden. Likewise, the reason for offering the $500 deductible maternity option is that if the person really wanted only the maternity coverage he would go somewhere else to obtain full maternity coverage. Premature birth claims, as most of you know, (the claims in excess of $100,000) have led to the perponderence of the shock claims over the past couple of years. We have found that after going to this new plan, 80% of our new business is being written under the no maternity option. Previously all of our business contained maternity as any other disability coverage. Our reps love the new option. They argued somewhat against it in the beginning, but now they realize that we have opened up a market that may be four times the market we closed off.

We also instituted substandard pooling. Based upon a case by case joint group claims/group actuarial evaluation, cases that either had a high frequency of claims or chronic claims were placed in a substandard pool. In this way we attempted to make our mini-group past experience credible. Credibility is a measure of your confidence in using past experience to predict the future. We looked at cases with either a high frequency of claims or chronic claims and these cases received rate increases up to 100% more than our standard manual rates. We needed this technique to deal with the following mini-group problem. In a mature trust, which is one that has undergone several rate increases, the better groups which are not concerned with having to resatisfy the pre-ex or underwriting limitations, tend to leave and the poorer groups tend to stay. You get into an assessment spiral. The actuary is in a quandry if he wishes to rate existing business and new business at the same rate level. It is desirable to keep the same rate level on both because a broker who has existing business with you and is trying to sell new business with you will be very confused if he sees two different rates for the same type of group. The actuary finds himself in a Catch 22 situation since if he sets the rates at a proper and saleable level for new business, he will be vastly underrating the existing business. I have done studies when I was in consulting to see how much first year underwriting is worth (and this was for a company that didn't do nearly the quality of underwriting John Alden does). I found that due to first year selection, select morbidity is 70% or less of ultimate morbidity. It is a substantial amount of selection. Likewise, if the actuary rates at an adequate level for existing business, new business rates will be unsaleable except to the worst groups. If a group chooses your rates when they are very high, they probably know more than you do. The substandard pooling project enabled us to break out of this Catch 22 situation and allowed us to set overall adequate rates on our existing non-substandard business, and to charge a proper rate level for new business with both of these rate levels being the same.

The last major thing we did on February 1, 1983 is something that Paul has already talked about. We instituted a cost containment unit within our claims department. The main activity of this unit is to use physician profiles to get back to a physician and request him to lower his fee. We deal mainly with surgery charges. We have four employees in our two claims offices in Minneapolis and Miami who do this. John Alden is spending about $125,000 a year in salaries for these people. Our average monthly savings from this unit has been $60,000 a month. This leads to a net bottom line profit of approximately $600,000. To put this figure in perspective, please realize that to achieve the same bottom line profit, we would have had to have written an additional annual premium in excess of $10,000,000, or 10% more than our current total block of mini-group business of $90,000,000. So it was a substantial profit that we obtained from operating this unit.

MR. SHEMIN: What percentage of your in force business had to be placed in your substandard pool?

MR. WINKELSTEIN: About 6% of premium which was equivalent to 25% of the claims. Remember the way we determine what goes into a substandard pool. These are cases which are expected to remain at the same level of high claims.

MR. SHEMIN: How about new business? Does that ever get placed in the substandard pool?

MR. WINKELSTEIN: We have a rate structure with a six month "honeymoon" where rates are guaranteed for six months. No group that had been on the books six months or less has been put in.

MR. STEPHEN N. STEINIG: How are your claim systems and your claim statistical systems structured to allow you to monitor chronic claims and frequency of claims? Do you have diagnosis codes in your claims?

MR. WINKELSTEIN: It was a backbreaking job. We pulled information off our claim file. We did an initial screen, and we picked out all cases that ran paid loss ratios in excess of 100%. Then we sat down with the claim department over the course of three or four weeks and just went claim file by claim file. Of the ones we screened only about 20% fell in substandard pool. The other 80% we deemed to be shock claims or maternity claims, or something that was unlikely to repeat.

MR. ALAN M. THALER: What was the spread that you said that you had between your substandard rate classification and your new business rate?

MR. WINKELSTEIN: We set up two substandard pools. The higher pool was 100% over the manual rates. The lower pool was 30% over the manual rates. We have advised the cases that were placed in the pool that if they have favorable experience in the next year or so, it is likely or probably that they will be removed from the pool.

MR. EARL L. HOFFMAN: I have two questions. First of all, you mentioned the $500 deductible maternity options for under five lives. From five to ten lives, do you offer regular maternity as any other illness coverage? Also, you mentioned in discussing the restrictions on maternity coverage that by doing this you hold down the cost on the premature birth claims, but wouldn't a premature birth be covered anyway as a newborn dependent?

MR. WINKELSTEIN: In answer to your first question, we do offer maternity coverage as any other illness for groups of five to ten lives. However, we accept no group with a person who is already pregnant. The answer to your second question is yes. But, we feel that by not offering a full maternity option for the smaller groups, we would not sell any maternity to smaller groups. If the employer wanted full maternity he would get it elsewhere. So we won't have the maternity claim, we won't have the premature birth claim. Analyses of what premature birth claims are costing companies may be causing them to understate their maternity cost. Premature birth claims should be considered as a maternity cost. By not offering the maternity coverage, we avoid antiselecton by the insured.

MR. THALER: On the matter of cost containment, I share the view that benefit controls are not working out very effectively. It is more window dressing for the customer that is looking for cost containment. You give him what he is looking for, but he is not necessarily buying anything. There is a lot more substance in honest to goodness hard work tracing claims in the manner that Mr. Winkelstein suggested through monitoring doctors or technicians. Another method that we have been urging is pre-authorization system similar to what is used in dental. You have a form which the claimant takes to his physician. The physician indicates the nature of the surgery that he plans to perform and what his charge will be and the insurance company would indicate how much they will allow. That means that the debate goes on before rather than afterwards. Of course, in emergency situations, this idea is not practical and there is also the situation where the doctor may claim later that he had to do much more than he had planned to do initially.

MR. MCCASKEY: Our traditional approach to the smaller end of the group market has been, at least in Illinois, that about a 90% loss ratio will be a break even point for us in the two to nine life market. This is a much higher loss ratio than most of our competitors who are being much more selective than we are. Our position has been that if we can keep the difference in morbidity in the range of 15 to 20%, we are still maintaining a very good overall position in the marketplace. The only concern I have, and it's a minor one, in hearing the John Alden approach is that if all the companies had been taking that approach for the last five or six years, I would strongly suspect that we would all have nationalized health insurance by now because we wouldn't be able to stand the heat of so many people in the marketplace not being able to get coverage through any means. The answer for us is an extremely streamline sort of operation on one end that hopefully in terms of total price more than offsets the morbidity difference.

MR. HOFFMAN: Jerry, you mentioned letting brokers only fool you once with bad business. I wonder how that works and how the criteria for deciding when you have been fooled ties in with your substandard case criteria. How do you determine in the case where there is a heart attack nine months after the business is written, whether in fact a broker knew anything about that. Whenever we complain to an agent, he insists he knew nothing about it and cannot be held responsible. Sometimes you are suspicious of that. You do believe him but you are still very upset. I was just wondering what your experience is like.

MR. WINKELSTEIN: That is very true. It is more art than science. We have an early warning system on a quick claim. If we get a claim that comes up soon after the effective date of the case and it is a sickness type of claim, a back claim, mental or nervous claim, we will look suspiciously. We will go back to the broker. We really look at our quick claim system and if a guy has two suspicious claims we will investigate. Once we are convinced that a broker gave us a bad case and that he knew about it, we will cut him off. There is no double talk about it.

MR. KEITH DUBAS: Is there a trend to change plan design to increase deductibles or coinsurance borne by the employee?

MR. WINKELSTEIN: On the mini-group size, which may not be typical of your business, we are selling more plans with $250 and $500 deductibles. We don't offer $1000 deductible now, but we will in the future because we are getting demands for it. We see more demands for higher deductibles and even higher co-insurance billings.

MR. SHEMIN: We are also seeing in the 3 to 50 life area, a definite shift to $250, $500, even $1000 deductible, although it is not always clear whether that deductible is really the plan deductible or just a policy deductible, with the employer making payments below it.

MR. JAMES C. CHARLING: I am interested in any lapse information that you have on your mini-groups. Also, do you have guidelines for underwriting those small businesses with poor persistency track records?

MR. WINKELSTEIN: No, we have nothing in our underwriting guidelines. We see that about 30% of our groups are not paid as billed, due to either a new employee or a terminated employee. We know that our insured population is changing rapidly every month. Since 1982, our lapse rates were at the 35 to 40% range. With the move to substandard pooling, we expect in 83 and beyond to return to a more normal rate, which would be around 25 to 30%. When we do our GAAP assumptions, we amortize expenses over two and one-half years so that the 40% fits in line. But we do that to be conservative. A more normal lapse rate would be around the 25% level.