RECORD OF SOCIETY OF ACTUARIES
1983 VOL. 9 NO. 4

MANAGING THE GROUP INSURANCE RISK IN TODAY'S ENVIRONMENT

Moderator: TED L. DUNN. Panelists: JOHN K. AHRENS, ROBERT J. DYMOWSKI, RUSSELL HENRY. Recorder: KENNETH K. LAU

1. Limiting the risk
2. Marketing strategies
3. Underwriting and cost strategies
4. Uses of reinsurance
5. Federal tax impact
6. Getting out of the business

MR. TED L. DUNN: My name is Ted Dunn with the Provident Life and Accident Insurance Company in Chattanooga, Tennessee. Our other panelists are John Ahrens, Director of Group Reinsurance with the Lincoln National Life Insurance Company in Fort Wayne, Indiana, Russ Henry, Vice President and Group Actuary with the Pan American Life Insurance Company in New Orleans, and Paula Sedlacek, Actuary with Milliman & Robertson Inc., Wayne, Pennsylvania. Paula works with Robert Dymowski who is also with Milliman & Robertson, Inc., in Wayne, Pennsylvania and she will present Bob's remarks since he is unable to be with us today. Our recorder is Kenneth Lau, Assistant Vice President and Associate Group Actuary with the Provident Life and Accident Insurance Company in Chattanooga. Each panelist will present prepared remarks and afterwards we will be open to any and all questions.

MS. PAULA SEDLACEK: As indicated in the Society's description of the Sessions formats, an open forum is intended for broad discussion of a topic and is structured to include substantial audience participation. Thus, my comments are intended to provide an outline of points which I consider significant, with the hope that the audience will have additional comments or questions which will develop them in more detail.

Underwriting Strategies

My first topic of discussion is the development of underwriting and cost strategies related to managing the group insurance risk in today's environment. In beginning my discussion about underwriting, it seems appropriate to reflect for a moment on a definition of underwriting. This would be that underwriting is the selection and retention of individual risks consistent with the rating assumptions and the profitability objectives of the group carrier. The successful functioning of underwriting has always been a key element in the success of any carrier. I believe that today's environment, characterized by continued high medical cost trends, changing demographics, emphasis on cost containment, competition from alternate delivery systems, the widespread prevalence of self-funding programs, and continued competition with other carriers, has increased the importance of underwriting, as well as making it more complicated than in the past.

Examples of these aspects of today's environment, and their implications for the development of underwriting strategies, include the following:

1. Changing Demographics - You are probably familiar with statistics which indicate that the family unit of father, non-working mother, and children at home makes up only 20% of the total number of employee units covered by group insurance. This is, of course, due to the more significant number of women in today's workforce, as well as changes in family structure. Such changes in group composition require reconsideration of traditional underwriting requirements related to employee and dependent participation and the definition of full-time employees. In addition, the requirements of the Tax Equity and Fiscal Responsibility Act (TEFRA), making Medicare secondary coverage for Medicare eligibles till employed, and renewed interest in the extension of conversion benefits, or other benefits for unemployed individuals, must also be considered in current underwriting practice.

2. Benefit Offerings - Just as groups are no longer traditional, benefits being provided are similarly no longer traditional. Two of the major areas requiring careful underwriting consideration are the offering of flexible benefit programs and the offering of alternate financing or high deductible programs to groups. For the former, underwriting rules need to be developed which will minimize the anti-selection likely to occur in such situations, and which will allow for appropriate benefit configurations to be selected. In the case of the latter, underwriting requirements must deal with the ability of groups to handle the additional risks retained by them under such programs.

3. Reduction in the Pool of Available Groups - The movement of groups to various self-insurance arrangements has represented a significant reduction in the pool of available groups, particularly the larger sizes of groups. Since groups moving to self-insured arrangements are often better risk groups, groups remaining in insured or fully underwritten pools may be worse risks than the average, making the selection of desirable groups more difficult.

4. Competition with Health Maintainance Organizations (HMO) or other Alternate Delivery Systems - As in the case of groups moving to self-insurance, these programs may often target the better risk groups or may be more attractive to the better risk individuals in groups providing a dual choice option to their employees. Such competition may come from organizations associated with a group carrier or, more often, independent of the original carrier. In either case, underwriting rules must be established to deal with the inevitable anti-selection to be expected in such cases, and to recognize when the risk involved is no longer acceptable.

5. Multiple Employer Trust Programs - Such programs are currently very popular for small groups, and require tight underwriting controls for any chance of success. Underwriting considerations in such situations include:

   ... Guaranteed issue vs. medical underwriting
   ... Participation requirements
   ... Treatment of new entrants and late entrants
   ... Wearing-off of initial selection and re-underwriting after some time period or review of experience
   ... Benefit design

6. Renewal Rating Formulas - In the extremely important medium size group market, underwriting must include the application of renewal rating formulas which produce competitive rate levels, promote rate stability and provide overall portfolio adequacy based on careful monitoring of all aspects of the formula and the factors being used in it.

Cost Strategies

The continuation of medical care inflation rates, especially hospital costs, at levels above those of the CPI has intensified pressures on carriers to contain and/or reduce costs for groups. We have discussed this within our firm and believe that we are reaching, or have already reached, the point where total medical care costs exceed the amount that groups are willing to spend. They are thus desperately searching for alternatives to reduce costs. It is therefore essential for group carriers to respond with the development of cost containment strategies.

Typical areas of such response include the following:

1. Benefit Design - Several major groups have reduced benefits, and groups appear more willing than ever to consider such benefit reductions via the use of co-payments and deductibles. This appears to be a significant factor in the importance of Comprehensive Major Medical products in the marketplace today. In addition to such factors, carriers are also introducing alternatives which are intended to provide incentives for the use of out-of-hospital vs. in-hospital facilities.

2. Claim Control - With profit margins for group insurance being as small as they are, it is extremely important to maintain tight control over claim payments. This control should assure that benefits are payable on only eligible individuals and only in accordance with the provisions of the contract. Particular emphasis may be placed on a review of usual, customary and reasonable payment levels to physicians, and to the auditing of large hospital claims. In addition, carriers are becoming more aggressive with regard to coordination of benefits recoveries and the use of their rights under subrogation provisions of contracts. In such situations, groups should be kept informed of the savings being escheated due to the effectiveness of such programs.

3. Group Utilization Reports - Large groups in particular want more information than before about the utilization of their benefit programs. Thus, carriers are developing such reports for both insured and ASO groups for the purpose of reviewing them with the groups and providing recommendations for possible changes to improve the effectiveness of their programs or to identify areas of possible abuse.

4. Development of Alternate Delivery Systems - After a fairly slow start, HMOs are beginning to gain considerable momentum and are being backed or developed by a number of group carriers. The Preferred Provider Organization (PPO) is ostensibly a newer idea (although the basic ideas go back to the origination of Blue Cross and Blue Shield Plans almost 50 years ago) and is experiencing considerable interest with regard to both hospitals and physicians. You may recently have read about PRUNET, a PPO arrangement developed by Prudential which incorporates a Diagnostic Related Group (DRG) payment mechanism for hospitals.

   While it would appear necessary to have fairly significant penetration in a given geographic area in order for such programs to be most effective, they could be of considerable importance with regard to individual major groups.

   These arrangements appear to offer an opportunity to take advantage of an apparent willingness by providers to maintain or increase their own market shares, as well as limiting the effect of cost shifting likely to be caused by the TEFRA limitations on Medicare and the new DRG reimbursement process.

5. New Reimbursement Mehodologies - The use of the DRG payment mechanism by Medicare has caused considerable interest by carriers or large groups in the development of comparable systems. As in the case of the Prudential arrangement, these can be combined with a PPO to provide payment in full or as a new form of indemnity benefit to promote cost sharing.

Getting out of the Group Business

In my last few minutes I would like to address some comments to the question of companies getting out of the Group business. We have had an opportunity to observe several companies exiting the business recently, and noted that factors affecting their decisions included the following:

1. They were unable to make a consistent profit in Group, or to have growth in profits in Group comparable to other portions of the company.

2. They lacked an appreciation of the Group risk, particularly the cyclical nature of the business.

3. Consistent with their lack of appreciation of the risks involved, some of these companies lacked surplus adequate to support the Group risks. In this regard, it shold be noted that Best's formula for company ratings essentially requires 25% of Group A&H premiums as the surplus necessary to support this line.

4. Some of the companies were unwilling to make the commitment of surplus, personnel, and EDP resources needed to acquire, monitor and administer their Group operations effectively.

5. Finally, in view of limited resources, overall decisions were made that other areas of company operations represented a greater potential return on investment than did group.

In terminating group operations, companies should consider the potential value of their block of business to another carrier. Factors to be reflected in such valuations might include the following:

1. What is the potential value of existing business if transfereed to another carrier, subject to the new carrier's rerating and possible benefit changes? While any value is obviously related to the overall adequacy of current and future premium rates and the likely persistency of the business, a new carrier may see the acquisition as an opportunity to broaden its geographic coverage and to add to overall volume without the usual acquisition costs.

2. How adequate are claim liabilities? While any shortfall would naturally be absorbed by the company in the course of ongoing operations, on termination any such shortfall would need to be recognized as part of the transfer to a takeover carrier.

3. Is there any potential profit in reserves being held for waiver of premium, long term disability or paid-up life benefits? If these are still being carried on a statutory basis, they should represent a source of potential profit if restated to reflect more realistic assumptions regarding interest, mortality or morbidity.

4. Does the marketing force have any potential value? This can be measured in terms of the production capabilities of the marketing group, assuming that it might be transferred to a new carrier as a block.

Companies are also concerned about their ability to place existing group staff with the new carrier. In any case, it is necessary to consider temporary staff requirements while winding down the operations. Last but not least, companies must also consider the effect on the overhead allocations of the balance of the company if Group operations are terminated. This will, of course, vary from company to company depending on the composition of the Group expenses between fixed and variable items.

I will be interested in your comments or observations regarding any of the above.

MR. RUSSELL HENRY: I have a few comments on the Limiting the Risk and Marketing Strategies topics. The environment of the past two to three years may be characterized by high medical inflation, high interest rates, significant cost shifting in the health sector, rapidly changing products, heavy government intervention, adverse court decisions, high policyholder interest in some degree of self-insurance, and increasing medical utilization.

Limiting the Risk

Inflation, Cost Shifting, & Utilization

Escalating Federal Deficits coupled with increases in the money supply have triggered increasing cyclical inflationary highs. This together with cost shifting and utilization increases has recently produced the highest medical trend factors I have seen in 25 years. Two risks to insurers are evident here.

1) A continuation of this trend in the political arena could trigger runaway inflation. There are many examples around the world of economies which developed hyperinflation with annual rates in some situations exceeding 100%. Should this occur the prospects for financial solvency would be severely threatened under the typical 12 month rate guarantees prevalent in group medical contracts.

2) Predicting trend factors is extremely difficult. If we estimate low, we lose money. If we predict correctly, but use a higher trend factor than competition, we lose business.

The best method of counteracting hyperinflation is to eliminate the rate guarantees. Other useful tools for limiting the risk would be to increase margins of safety in renewal rating formulas or to improve methods of estimating trends. These last two approaches would probably prove ineffective under a hyperinflationary scenario. Another protective device on large cases is to utilize Administrative Service Only (ASO) contracts. The degree to which the risk is reduced would depend upon whether individual and aggregate stop loss features are utilized and at what level they are triggered.

I wonder whether insurers will eventually be perceived as having shirked our duty as risk takers by promoting contracts shifting risks to employers for which they are unprepared.

High Interest Rates

High interest rates have triggered an increased awareness by policyholders of reserve funds held with insurance companies and the interest credits received thereon. This in turn has triggered the design of various products, such as ASO and Minimum Premium plans, enabling policyholders to gain access to reserve funds. The movement to such plans has caused a decrease of reserve funds in most group departments offering such contracts to their larger policyholders. This decrease has

occurred during a time of rising interest rates. Unless the investments backing these reserves are very short term such liquidation of reserves results in investment losses. These investment losses result from liquidation of investments at a market value loss or by reducing the amount of new cash available to invest at current high interest rates. Moreover these losses may not directly show up in the operating statements of the group line.

The method of allocating interest to the Group Department and the method the Group Department uses to credit interest to policyholder reserves also has a direct bearing on a policyholder's desire to move reserves in order to maximize yield. In a rising interest market, Average Interest Allocation Methods are deficient compared to Investment Year Methods. But even Investment Year Methods may not be wholly adequate since policyholders whose reserves were established when interest rates were low might be unhappy with their rate of return if current yields are much higher. This argues for investing group reserves in short term maturities. Then interest credits could follow the current market in both directions minimizing the policyholder's ability to select against the insurance company.

Alternate Funding

Minimum Premium Plans

Where a policyholder agrees to pay a terminal premium equal to the unfunded reserve, an additional credit risk has been added to the insurance contract. Some insurers do a credit evaluation, others may require a Letter of Credit or pledge of collateral. With the high level of bankruptcies, are these devices safe? If not, are companies adding an appropriate risk charge to their retention?

Extended Grace Periods

A number of companies have used 60 or 90 day grace periods as a simple device to give policyholders access to reserve funds. Our company has already had one policyholder in the oil service field go bankrupt that had a 90 day grace period. We had no Letter of Credit or collateral and were therefore unable to collect the Due and Unpaid premium. In the future we will require a Letter of Credit on policyholders in certain industries.

Premium Tax Risk

Under Minimum Premium plans what risks are involved if more states follow California in requiring premium tax on these programs? While most contracts have a clause which enables the insurer to have recourse to the policyholder for premium taxes assessed, will we be able to collect such retroactive assessments?

If the policyholder is bankrupt there is obviously no possibility of collection. If the policyholder is solvent this debt should be collectible. However, amounts involved with large policyholders could be significant. One must wonder how these contractual clauses would hold up in court, especially if a policyholder claims this liability was not properly explained.

Swiftly Changing Products

In today's environment the rapidity of shifts in all business has increased. This is particularly evident in the electronics industry and the financial services industry. Under this environment several risks are introduced. If a company waits too long to introduce a new product it may lose existing business and be unable to maintain its area of new business. On the other hand, by moving too swiftly one may find the market shifting to modifications of the original product entailing costs to retool policies, computer systems, etc. In either case the risk of being premature or too late is an expense and production risk. There is no easy way to limit this type of risk other than to use sound business judgment in determining when to offer a new or modified product.

New products also involve pricing risks where there is no appropriate experience data available. A new product may become obsolete before start up costs have been fully amortized.

Contractual Controls

Some risks can be reduced or eliminated by contractual wording appropriate to the objectives. This is particularly useful in areas where utilization tends to be high when benefits are liberal, such as mental and nervous coverage. Alcohol and Drug Abuse coverage is another area where savings can be achieved. However, more and more states are limiting our contractual right to restrict such benefits as well as mandating benefits that we would not usually intend to cover, such as social workers. In many cases the use of A.S.O. contracts gives more latitude in contractual construction but more states are moving in the direction of limiting the flexibility in all benefit plans, whether insured or not.

Governmental Laws & Court Decisions

During the past several years we have witnessed a large number of laws and court decisions having an impact on the products we write. Some of the more significant were:

A. Federal

1. TEFRA
   a) Stop Gap Tax
   b) Medicare made secondary
2. Price controls by executive order
3. Withholding requirements on accident and sickness disability benefit through Omnibus Reconciliation Act of 1981 (At Pan-American, the cost of the computer program was twenty times the amount withheld in the first year!)
4. 1099 reporting under IRS code
5. Age discrimination elimination under Age Discrimination in Employment Act
6. Pregnancy Discrimination Act requiring maternity to be treated the same as any other disability.

B. State

1. Health conversion benefits and rate requirements
2. State mandated coverages

C. Court Decisons

1. Norris decision affecting sex distinct rating
2. California Supreme Court ruling on taxation of alternate funded programs

Each requirement has its own set of risk and/or expense implications and time does not permit a detailed analysis of each one separately. One of the more frustrating aspects is the lack of sufficient lead time to implement appropriate administrative procedures and to adjust prices to cover expenses and benefit changes. The wide range of implications of the various programs makes it impossible to formulate any overall advance strategy for limiting these kinds of risks.

Marketing Strategies

Group Profit Center Diversification

At Pan-American we are organized by profit center. The three major profit centers are Domestic Group, Domestic Ordinary and International. Each profit center has its own sales, actuarial, administrative and underwriting staff under the control of a Senior Vice President who reports to the President. Several years ago in the Domestic Group Profit Center we undertook to explore ways to diversify in such a way as to help stabilize our profits against the cyclical swings in the health line. At the same time we wanted to give our group field force additional avenues of compensation especially useful during cyclical peaks in the medical area when production typically declines.

We found two products that made sense to our profit center, namely Group Pension and Mass Marketed Individual Policies to employees on a payroll deduction basis. These products fit in well because:

1. They are marketed to employers covering their employees.
2. They are marketed through agents and brokers with a Group representative coordinating sales and service.
3. They are not subject to the cyclical swings of the medical field.
4. We could capitalize on agent, broker and policyholder contacts already established.

The Group Pension products are limited to Money Purchase and Investment only type products since that required a minimum investment to bring on stream. Our first sales were in 1979. At this juncture we are extremely pleased with the overall results.

The Mass Marketed products are tailored around $3 to $5 per week payroll deduction. The basic product line consists of Employee Whole Life with waiver of premium and accidental death and disablement benefit (AD&D); Spouse Whole Life, Spouse Term Rider and Children's Riders. We started marketing in '82. At this juncture we are very positive in our prospects for Mass Marketing to make a significant contribution to the Group Profit Center. We are currently looking at several product variations including Universal Life.

Other Marketing Strategies to Limit Risk

Sales management emphasis as well as specific bonus incentives to promote group life, accident and sickness benefits, dental and ASO have been incorporated for several years. In addition we pay bonus on rate increases if sold on time and as requested by Underwriting. We feel strongly that this has contributed heavily to a high persistency rate.

We also emphasize the medium size cases in the range of 150 to 800 lives. Our combined strategy is for high quality products with superior service. We feel the medium size groups exhibit more persistency and appreciate better service. They are also less gross price sensitive than smaller cases although net cost becomes important. On the very large cases the profit margins are squeezed due to competitive factors.

Recently there has been an increased interest by carriers in offering Dental programs that had not offered them before. Also, Blue Cross/Blue Shield organizations are actively pursuing Dental capitation programs structured like an HMO. A specific package of services is offered for a set fee per month per family covered. These programs are particularly active in New Jersey, Pennsylvania and the Midwest. Dentists are also showing more interest in aligning themselves with such plans.

Since it is difficult to compete on price only, an approach which has some merit is to structure a medical program with combinations of benefit, price and self-insurance to be different enough so as to make direct comparisons difficult. An example of a program fitting this category might be a $1,000 front end deductible but with the employer self-insuring $900 and the employee paying the first $100. An aggregate stop loss feature may be added to the policyholder's self-insured portion.

With some ingenuity a fairly attractive package could be offered which did not increase the policyholder's liability significantly. Unique approaches should enable the insurer to build in somewhat larger profit margins and thereby reduce risks.

MR. JOHN AHRENS:

Uses of Group Reinsurance

Group reinsurance is a very important management, financial and planning tool. Senior management should evaluate how to best use reinsurance to meet their goals. Some of the uses of group reinsurance are smoothing operating results, increasing marketing potential, access to a variety of services and sound financial planning.

1. Smooth Operating Results - a major use of reinsurance is to smooth operating results, usually on a calendar year basis. There are several factors which can upset the planned results.

   Protect bottom line from fluctuation. First, excess reinsurance can be used to reduce the potential bottom line impact of a relatively few large claims. In the past, life and AD&D were frequently most commonly reinsured on this basis. Although higher guaranteed issue maximums in group life are continuing, the real problem area is large medical claims since the vast majority of persons insured now have maximums of one million dollars.

   Rather than spend time relaying horror stories of large claims, let's think back five years to 1978. Most persons back then would have said its almost impossible to have a medical claim in a calendar year that exceeded $100,000 and the expected cost would be pennies per month. Now, the expected cost for that is measured in dollar per employee per month, over a tenfold increase.

   What was said of claims above $100,000 five years ago is being said of claims above $500,000 in 1983. Such claims will grow tremendously in the near future. Many managers who never thought about excess reinsurance will do so in the next few years, hopefully with foresight rather than after-the-fact.

   Minimize impact of a few large groups. Second, another need is to minimize the impact of large cases. Frequently, a company may have the opportunity to write a group much larger than their usual business or of an usual nature. This may be highly desirable because of its larger premium base or high profit potential. However, it could have a significant impact on the bottom line so a reinsurer may be sought to accept a majority of the risk on a quota share basis. With a proper ceding allowance, the company should be able to more than cover its expenses and share proportionately in the profits.

   Minimize impact of a minor product line. Finally, reinsurance can be used to lay off the majority of risk on minor product lines. This takes out fluctuations in the same way as just described and such arrangements are usually handled on a bulk basis to simplify administration.

2. Increase Marketing Potential - a second major use of reinsurance is to increase marketing potential by various approaches.

   Expand sales in spite of low level of surplus. First, quota share or coinsurance arrangements can be utilized to alleviate strain on surplus that can occur from increased selling in specific lines. One example is medical where a company's Best rating could be affected by a high ratio of group A&H premium to capital and surplus. Another example is on credit coverages where the statutory reserves exceed gross premium less commissions in the first few years.

Expand product breadth. Second, reinsurers can put companies into a particular line of business by providing the necessary expertise and taking most of the risk. This allows companies to expand their product breadth without a commitment of their own resoures. The two products that are most commonly provided through reinsurance include long-term disability and the aggregate and specific medical coverage on self-funded groups.

Increase issue limits. Third, ceding companies can compete with the very large group companies on group life non-evidence issue limits with excess backing from a reinsurer. In addition, the availability of excess medical reinsurance has allowed all companies to offer million dollar maximums on group medical.

3. Services - a third use of reinsurance which is often overlooked is the service and advice a reinsurer can provide.

   The range of services can vary greatly by reinsurer. Some reinsurers only take risk and provide no services. A few will discuss trends they see in the marketplace which they have gathered through discussions with their clients and prospects. Finally, some reinsurers have a significant direct group division within their corporation and make their expertise available to reinsurance clients. This could include their underwriting and rating manuals, training in underwriting or claims and help on specific questions or issues in policy language, claims and other areas. The perceived value of these services can often be the major factor in choosing a reinsurer.

4. Financial planning - a final use of reinsurance is in financial planning.

   Reduce tax liability. Bulk reinsurance arrangements have been very important tools in reducing company tax liabilities beginning in about 1978 and continuing through 1982. This is a very specialized form of reinsurance since such arrangements may disappear as quickly as they came due to changes in the tax law.

   Protect capital and surplus. Protection of capital and surplus is a consideration. Very few companies are in a position where they run a significant threat to insolvency without reinsurance. However, for those smaller companies, reinsurance is a requirement to stay in business.

   Acquisition of other companies' business. Reinsurance can also be a financial tool for acquiring another group writers business. That point leads me into my second topic which is called getting out of the group business.

Getting Out of the Group Business

There has been considerable activity toward "getting out of the business" by group writers in the last twelve months. My company, Lincoln National, has been involved in the acquisition of several of these blocks. However, my comments on this topic today are of a general nature and point to the future and thus do not necessarily reflect past situations.

1. Manufacturing versus Wholesaling - it is important to note the distinction between manufacturing versus wholesaling of group insurance. Manufacturing is the various processes performed in the home office whereas wholesaling is the distribution of products, not necessarily your own, to marketers. Getting out of the business can refer only to the manufacturing end of the business, not necessarily the sales end.

   Getting out must be viewed as a long term solution to a long term problem. Many of the companies who have withdrawn from the manufacturing of group insurance have been controlled by large non-insurance companies. Viewing the group business from outside the insurance industry may have contributed to their decision. Some reasons for "closing down the plant" are:

   a) poor financial results;

   b) disenchantment of senior management caused by not understanding the cyclical nature of the business;

   c) problems with the Bests' rating because of the ratio of group premium to capital and surplus;

   d) no control over business and thus difficulty in raising rates;

   e) large capital expenditures required to update claim and administrative systems;

   f) lack of technical staff in actuarial and underwriting areas and lack of a sufficient data base for rating;

   g) lack of staff or size of block to justify developing cost containment features and to develop relationships with providers.

2. Methods of Getting Out - once the decision has been made, there are basically three ways to get out of group:

   First, we find a new carrier to place all cases with as they come up for renewal. This method would not involve reinsurance.

   Second, find a carrier to reinsure all business and liabilities as of a given date with any new business and renewals after that date being written on the new carrier's paper.

Third, simply terminate all business as soon as possible. This third option will not be discussed further since it should be much less desirable than the first two options.

Although the first two options may appear simple and straightforward, the great variety of coverages making up the business as well as the size of the block usually make the actual implementation a very difficult process. The decision between the first two options will usually be based on the financial terms proposed in the existing block.

3. Considerations in Choosing an Acquiring Company - what considerations are involved in choosing a company to acquire your business? The considerations make sense if you think in terms of their being a manufacturer and your being the wholesaler.

   Products Offered. - First, does the acquiring company offer a full range of group products and are they knowledgeable in each? What is the industry reputation of the acquiring company and its products? Since your sales force will be marketing them, their success will be affected by the quality of the company's products.

   Services. - Second, there are service considerations. How will the acquiring company respond to the needs of your sales force, and how smooth will the transition be? It is very helpful if you have previously had a business relationship with the acquiring company in order to increase your comfort level as well as theirs. A favorable national reputation is very important. This question of services can best be answered by examining your objectives and determining to what extent the acquiring company meets them. These objectives can range from simply getting out of the existing block as soon as possible to expending the breadth and amount of sales out of your agency system.

   Financial Package. - Third, the financial terms are important and should take care of the existing block as well as new business. Generally the long-term consideration is new business and the key is the commission and override to be paid. The acquisition of the existing business may amount to more or less a fire sale and the withdrawing company can't be as demanding in its terms.

4. Considerations in Choosing a Block to Acquire - what are the considerations for a company looking to acquire business? Before entering into this process a potential acquiring company must consider the potential advantages of such an arrangement.

   Spreading Overhead Expenses. One is spreading overhead expenses. Long term reduction in per unit costs in systems and technical areas is a key potential advantage. However there are significant short range costs and if procedures are not already efficient, desired long term savings will not materialize. The size of the block acquired is important. There is almost as much effort involved in acquiring a 6 million dollar block as a 60 million dollar block so larger blocks generally have more appeal. The potential for recovering previous deficits can add to the appeal of a block.

Addition of Key Personnel. Another advantage can be the addition of key persons from the withdrawing company. For example, experienced claim examiners and underwriters previously with the withdrawing company may be convinced to join the acquiring company.

Expansion in Low Penetration Markets. A third advantage would be to acquire the business of a company with a strong regional network in an area where you don't have a particularly strong market penetration. This could provide an expansion in new business as well. An important aspect here is whether or not the business is controlled by a company's own agents or group representatives. Broker ties can also be important whereas, Multiple Employer Trust (MET) business dominated by a third party administrator would probably not be so appealing.

5. Mechanics of the Acquisition Process - the general mechanics of the acquisition process can be summarized as follows:

Preliminary inquiries. First, the preliminary inquiries. It is usually preferable for a prospective withdrawing company to approach possible acquiring companies while their thoughts are still in a fluid state. The acquiring companies' input can help shape their thinking and prevent unexpected problems. The existing block, sales staff and employees will be more valuable to a potential acquirer if the news of the arrangement is presented in the most attractive light. In some instances the decision to get out of group has been made public before discussions with acquiring companies. This is not good since it negatively affects policyholders and the sales force, not to mention the bailing out of employees.

Assigning a Transition Team. Next, a transition team must be assigned and set up by both companies to coordinate activities in all important group areas including: underwriting; claims; contract analysis; actuarial; legal; agent licensing; communications - with the field, employees and policyholders; marketing; executive account contact with key policy-holders; and financial reporting.

Handling of In Force Business. The third step is determining the handling of in force business. Generally all risk is assumed on all business as of a certain effective date using a 100% coinsurance reinsurance agreement. The reinsurer may or may not be responsible for all administration as of the effective date. Then as each case comes up for renewal the case is renewed on the reinsurer's policy forms. Usually within a year, the reinsurer is responsible for all administration.

Handling New Business. Fourth is the company's handling of new business. The withdrawing company may be compensated for new and existing business that is rewritten on the acquiring company's paper through a national brokerage arrangement. Commissions are paid directly to the withdrawing company agent and expense allowances may be paid to the company to cover indirect marketing expenses.

Financing Term. Finally it comes down to the financial terms. The withdrawing company may be paid for the existing block in several ways. The terms may include:

a) an upfront fee;

b) a ceding allowance to cover transition expense; and/or

c) a flowback of some of the future profits generated.

6. Summary - In summary, the tremendous demand for sophisticated claim systems, detailed management reports, accurate rating, cost containment programs and negotiations with providers is demanding greater capital investment in both equipment and personnel. However, competition from many sources is keeping profits at a low level which discourages such investment. This environment suggests that many group writers should consider the option of removing themselves from the manufacturing end of the business and concentrating instead on wholesaling.

MR. DUNN: We've had comments about managing the group insurance risk and hopefully we've made some money. If our top management didn't tell us to get out of the group business, the next question is "Do we get to keep any of the money, or does it all go to the federal government?"

1. Tax Law Prior to 1982 - prior to 1982, life insurance companies were taxed on the basis of the 1959 Life Insurance Company Tax Act (LICTA). LICTA was a multi-phase tax system. Under this multi-phase system, it was possible for different life companies to have identical items treated differently for tax purposes.

Under this act, group insurance was subject to certain special treatment. Group experience rating refunds were typically classified as dividends for tax purposes. The 1959 Act contained a provision for a special deduction known as the "Group Special Deduction" which was equal to 2% of all group premiums subject to a certain limitation. Under LICTA, both dividends and the group special deductions were subject to possible limitations on the amounts which could be deducted in determining a company's taxable income. Additionally, for companies in certain circumstances where their gain from operations after dividends and special deductions was in excess of their taxable investment income, one-half of the excess of the gain from operations over taxable investment income was deferred from taxation.

Under the multi-phase system, companies could be taxed on gain from operations only, on taxable investment income only or a combination of both. A company which was taxed solely on its gain from operations could only deduct $250,000 of group retro rate credits paid and group special deductions. A company taxed solely on taxable investment income might be able to deduct its entire amount of group experience rating refunds and still be able to receive some benefits from the group special deductions, but it was also possible for a

company in this situation not to receive a full credit for retro rate credits paid to their customers. On the other hand, companies taxed on both gain from operations and taxable investment income were allowed to deduct the entire amount of retro rate credits, the entire amount of any group special deductions and one-half of the excess of the gain from operations over taxable investment income.

2. Tax Law for 1982 and 1983 - in 1982, TEFRA was enacted. A major provision of TEFRA was that a safety net was provided on the minimum amounts of dividends which could be deducted in determining a company's taxable income. Under TEFRA, stock life companies were allowed to deduct at least 85% of their dividends plus 85% of their non-par special deductions. For mutual companies this percentage deductibility was 77-1/2%.

   This meant, for instance, that those companies which would have been taxed under LICTA on gain from operations only were able to deduct at least the applicable percentage of their experience rating dividends and were not subject to a $250,000 limitation on the deduction.

   For some of the companies which would have been taxed only on investment income under the 1959 LICTA, an additional deduction could result. For those companies taxed on a combination of gain from operations and taxable investment income, no change in deductibility was brought about by this additional provision.

3. Life Insurance Tax Act of 1983 - the proposed Life Insurance Tax Act of 1983 (LITA) will do away with the multi-phase system and determine taxable income for all companies on an identical basis. Under LITA, all companies will receive a full deduction for the amounts of retro rate credits paid on group cases but the group special deduction and one-half the excess of the gain from operations over taxable investment income deferral items will no longer exist. Additionally, the effective tax rate for insurance companies will be reduced to 34-1/2% from 46%.

4. How does this proposed change in law affect the ability of companies in various situations to write group insurance? - this discussion will begin with the effect on stock companies. Mutuals will be addressed later. The change to this new basis will make it much easier for a company, which had previously been taxed only on its gain from operations under LICTA, to write group insurance. Under LICTA, it was very difficult for such a company to write group business because retro rate credits paid were usually classified as dividends and were subject to a total deductibility limit on the amounts which could be deducted of $250,000. When TEFRA came along, companies in this situation were helped tremendously by being allowed to deduct a certain percentage of these retro rate credits paid. However, these companies still had to add back into their taxable income, some amounts which they had paid out to their group customers as retro rate credits. Under the proposed law, these companies will be able to deduct all amounts paid or credited on any funds to their group policyholders in their capacity as customers.

With respect to companies which had previously been taxed only on investment income, the new act will probably provide a better environment within which to provide group insurance. However, this may not be true for all such companies. The reason for this is that all amounts paid or credited to group policyholders will now be deductible. Under the previous law, it was possible that all amounts paid or credited to group policyholders in their capacity as customers would not be deducted. However, it was also possible that all such amounts would be deductible plus some amount of group special deductions could also be deducted. It should be noted that the reduction in the tax rate from 46% to 34-1/2% will probably more than make up for the loss of any special deductions.

Companies which are taxed on both gain from operations and investment income will have lost the ability to deduct both the group special deductions and one-half the excess of gain from operations over taxable investment income.

It is quite likely that the loss of these deductions will not be made up by the fact that the coporate tax rate has been lowered. Therefore, it may be that companies which were in this situation under LICTA will have lost a favored status which they previously enjoyed.

All the above statements apply equally to mutual life insurance companies. However, LITA provides for an add-on income item in determining mutuals taxable income. It may be that the provision of group insurance will affect this add on item adversely and, thus, hurt the mutuals ability to write group insurance. Due to the complexity of the law, I am not prepared to address this issue at this time.

5. <u>What about amounts paid or credited to policyholder funds?</u> - under previous law an insurance company, if it was unfavorably situated within the multi-phase tax system, had to be very careful how policyholder funds were constructed and how interest was credited to these funds. A company taxed only on gain from operations or only on investment income could not credit any interest to funds if this interest would be deemed to be dividends because the additional amounts of dividends would probably not be deductible.

   Under LICTA only certain well-defined funds qualified to have the interest credited on them be deductible under the investment income tax phase. Therefore, for insurers in this tax situation, it would sometimes happen that the insurer was not able to credit a before tax rate of interest on policyholder funds held. For companies that were in a combination of gain from operations and taxable investment income basis, all amounts paid or credited to policyholders were at least partially deductible. With the change from a multi-phase system to the new single phase system under LITA, all companies will be able to credit a pre-tax rate of interest to policyholder funds.

6. What about premium stabilization reserves - Section 810(6) Reserves? - LICTA specified that amounts held in connection with a group contract for the purpose of stabilizing premium charges would receive favorable tax treatment regardless of what tax situation the insurance company was in. The Section 810(c)(6) Premium Stabilization Reserves (PSR) treatment will continue in the new law as Section 807(c)(6) Premium Stabilization Reserves. However, under LICTA there were no restrictions on the amount of funds which could build up under a PSR. Under LITA there is a possibility that certain additional restrictions will be placed on these funds and that the insurance companies will have to justify the amounts which are held therein.

We would be happy to have any questions on any of these topics and direct them to any member of the panel or to all members of the panel.

MR. HENRY: I'd like to just add a comment to your comment on the taxabilities of mutual vs. stock. As I understand it, the mutual companies have what is called a tax surplus which is defined in the new law and 8% of the tax surplus is taxable at a rate of 34.5%. Therefore, a mutual company is at a disadvantage relative to a stock company.

The impact in the group area would be depending on how the company decides how to allocate a portion of that tax to the group line of business and if for instance you use the Best's grading formula and the tax surplus allocated to group health line is 25% of group health premiums, then the additional federal income tax is 8% of that number times the 34.5%. It could produce some significant tax costs to a mutual company. Now there's a lot of ifs and buts about how that may all shake down in the final tax law and in the final allocation process within a company.

MR. DUNN: I really think in all honesty that the tax situation in Washington and the additional cost shift which may result from the DRG regulation, which commenced effective October 1, 1983, may well be the two most serious problems the group business faces today.

MR. SANFORD HERMAN: I am with Guardian Life. I have a question for Mr. Ahrens regarding reinsurance. Under LICTA a lot of companies have been in the Phase I situation where they are taxed on investment income . I know that in my company some of our reinsurance planning is based on the fact that our big losses were not deductible. With the stop-gap legislation and the proposed LITA, our claim costs will be deductible. As a result, we've started to eliminate some of the reinsurance agreements or increase the threshold to which we are willing to accept risks. Do you see this as being something that would affect the volume of reinsurance being placed in the future?

MR. AHRENS: I would think that if you have $1.5 million of profit and you have an extra $1 million claim, that would bring it down to $500,000 profit and you'd still be taxed 34.5% of that. We see a growing demand for excess medical reinsurance because of the effect of one large claim on the underlying results.

MR. HERMAN: My understanding was that say you have a profitable operation and you had an additional $1 million claim and you were taxed just on investment income, then that $1 million would flow through to the bottom line without being able to deduct it, having no offsetting tax credit. Now you'll be able to reduce your federal tax liability by that. The impact of a big claim on a given company would be softened where it wasn't in LICTA.

MR. DUNN: I think I agree with what you say. Under the proposed tax act you will always get a credit for that claim, whereas under the 1959 Act you might or might not, depending upon where you were, have gotten a tax deduction for the amount of all or part of that claim.

MR. HENRY: In effect, the stop-gap Tax and the proposed tax act have the impact of dampening the profits when profits soar but also dampening the losses in a loss situation so that it tends to smooth out, the results, both good and bad, vis-a-vis, the prior law where we were being taxed on basically net invested income.

MR. CARL SULLIVAN: I work for Plan Services, Inc. We are a small group health insurance MET administrator firm, and we handle the business for twenty-five to thirty insurance companies for their MET blocks. The question of trend has been very pertinent to us when we review the business and to our various carriers when they are at renewal time to consider their rates.

Mr. Henry mentioned in his discussion of limiting the risks that a better estimation of trends would be one way to do that. I would like to hear any more comments that you might have on that and particularly some specific estimations of trend in medical claim costs, short range and long range, if you could offer that. I'm sure there would be many qualifications you might have to make on specific numbers but I would be interested in hearing them.

MR. HENRY: Basically our approach to the trend is to notice historically that they are cyclical in their nature and that it seems like every three to four years you go through these peaks and valleys and they tend to track with the CPI. Unfortunately, this is one of the more inexact sciences in predicting what is going to happen next year and what trend factors should you be using now. Typically what happens is in an escalating environment you tend to estimate on the low side and when the trend reverses like it is in our company right now, you estimated on the high side because while you are experiencing high deficits and losses, it is very difficult to reduce your trend and vice versa, when you're currently experiencing good profits it's very difficult to beef your trend factors up. I don't really have a good answer to your question myself; it's one of the areas where its particularly difficult, we use a lot of brainstorming, our more experienced people tend to have input into that decision and we watch it very closely.

One idea that might be helpful is you can set up what might be called an early warning system and you do that by setting up monitoring devices which raise red flags as things begin to get out of control. One of

those monitoring devices that if you're fully computerized you can do - but we haven't done it yet, but I want to - is to monthly track your large case surpluses or deficits. That indicator is fairly sensitive to the trend in both directions. By watching that, I think you can see what's happening and start to react to it fairly quickly. If I'm not mistaken Ted, don't you do that at Provident?

MR. DUNN: Yes we do and it's very helpful to us. It has one disadvantage - if you find out what's happening before your competitors do and react, you tend to lose a lot of business when the claims are going up. With respect to trend factors it would be inappropriate to discuss the extent of the factors themselves and we will not do so. Certainly trend factors have to provide for three types of increasing claim expenses. The first one is the price inflation of the unit cost of providing this service; the second is increased utilization and third is the cost shift. It's really difficult to get a handle on what kind of cost shift are we going to have in the future.

MS. PAULA S. SEDLACEK: I have another comment. Another important consideration in the trend is the impact of underwriting selection or antiselection in the group too. I think that it is especially pertinent that this question was raised in the context of the MET business. Ted talked about the three components - the ordinary cost utilization and impact of cost shifting, there is that fourth component that needs to be considered and that is the antiselection of the aging components or the wearing off of initial selection.

MR. AHRENS: One other point I'd like to add on trends, in excess reinsurance we've become more interested in what is our excess trend vs. the underlying trend everyone sees. One of the things we've found may be of some help in you determining your own trends.

From 1981 to 1982 on a very good block of stable and credible business of $20,000 excess the trend was 50% per capita. If you start thinking what you're doing with your trends, there could possibly be this excess layer which is growing at tremendous rate, which we believe is where a lot of the cost shifting is reflected. I hope that it may help you in determining your trends.

MR. HENRY: One other comment on monitoring devices, you can use a device called "measuring your protected premium". A simple illustration is if you had a case with an 80% loss ratio and a 10% retention you've got basically 10% protected premium. In other words, the losses can increase by 10% before it actually costs you any money and you're just cutting back the dividends at that point. You can measure the dollar amount of that in your operation, measure your retros, measure any contingency reserves and track that dollar amount incurred As inflation escalates that dollar amount tends to shrink and go negative on individual cases where you're in the red on a case and obviously have no protected premium. But that's another tool that can be very useful in watching the trends in both directions.

MR. DUNN: You will recall in Paula's comments that she made a very interesting observation about the shift of large group policyholders to a self-insured basis and that there was a perception that those that had shifted were by and large some of the better risks and that what is left for all of us to insure is a less desirable overall pool of groups. Certainly you would expect a less favorable experience in the future than in the past from the entire aggregate of companies. It was of interest that in the 1970's the Fortune 500 companies in the aggregate did not grow in jobs. In other words, the top 500 Fortune companies at the end of the 1970's had the same number of jobs that the Fortune 500 companies had at the beginning of the 1970's. All of the increase in jobs that occurred in this country in the aggregate came out of smaller and very small companies. We tend to think of the large jumbo risks as the more desirable ones and it looks like that some of them are aging, some of them are going to self-insurance and all of these things have some effect on your operating results.

MR. RICHARD SIEBEN: I would just like to toss one more thing into the environmental issues that were discussed at the early part. The cost shifting I assume that you are talking about for the most part is all the things that we are threatened with as a byproduct of federal action and the federal government sitting on the cost of public programs. We also talked about the PPOs and the HMOs and to certain extents they are capitation programs. What's happening with or at least what I feel is happening and have seen in some instances with the beginning recognition of a glut of supply in the institutional providers of healthcare and growing doctor glut facing us is that those organizations represented additional threat of cost shifting. Some of the sharper HMOs are starting to negotiate capitations, and discounts from billed charges far more aggressively than some of the Blue Cross organizations have done. As a byproduct now we have direct competitors in the marketplace who are buying at a discount where we are still writing contracts that are essentially reflecting billed charges based on usual customary fees. That adds another incidence of cost shifting.

MR. DUNN: Thank you Dick. I think that's a very pertinent comment. If we as insurance carriers of one form or another do not work out the financial arrangement with the medical care providers for the benefit of our customers and somebody else does then we will find that they are no longer our customers. What this leads to is that insurance carriers are going into PPO arrangements that they set up themselves. We have done this. Paula referred to some of the activities of the Prudential as an example. And yet another example is their HMO activity. All of this is a reflection of the pressure from the people who pay the bills that they are getting tired of paying so much more each and every year and nobody ever being able to restrain the increase in costs on a satisfactory basis. We need to address ourselves very stringently to all of these concerns.

MR. HENRY: I have a question for John. In taking over a block of business it seems that one of the critical factors is the ability to have a fairly decent persistency so that you don't take over that business and go through all the expenses and time and effort and only to have that case at renewal time go to some other carrier. Can you comment upon how the experience has panned out versus your assumptions? Did you assume fairly conservative persistency on that takeover business?

MR. AHRENS: I think to some degree our group division was a little pessimistic in making their assumptions upon the takeover in terms of their ability to renew the business and keep it on the books. From what I understand subsequently the persistency has been much better than they had expected.