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# SMALL-TO-MEDIUM SIZE GROUP MARKET (25 TO 200 LIVES)

*Moderator: FREDERICK P. HAUSER. Panelists: HENRY ESSERT, ANTHONY J. HOUGHTON, RONALD W. VERNIER. Recorder: ROBERT M. MUSEN*

. Recent financial experience
  - Impact on underwriting and selection practices.
  - Impact on benefit design and rate guarantees.
  - Techniques for monitoring financial results.
  - Is this market a profitable one?

. Trends in rating, funding provisions and product design
  - How much credibility should be given to individual case experience?
  - How have insurers handled outsized rate increases?
  - Is there a market for partially self-funded plans?
  - What has been the financial impact of cost containment provisions (second surgical opinion, ambulatory surgery, etc.)?

. Short and long term outlook for this market

MR. FREDERICK P. HAUSER: We want to give you a view of this market from different perspectives. Tony will be talking about if from the consultant's point of view, and he will give us sort of an overview of the market. Ron will be talking about it from the point of view of a large insurer where this is one of their products. Henry will be talking a little bit about it from the point of view of an insurer where this is their primary product. Just to set the stage here, we are going to be talking about a business that is basically non-individually underwritten -- almost no individual underwriting in these medium size groups. It is a marketplace where large insurers usually have special package products as opposed to tailor making the product for a particular customer, which you find in the larger group market. It is a market place with very high turnover -- at least lately, I believe -- and what I call churning. It is very price-sensitive as opposed to being perhaps administratively-sensitive, and it is a marketplace which recently has not been profitable for most companies, I believe. Tony is going to speak first, and he will give you his views of many companies' practices and particularly concentrate on the rating system.

MR. ANTHONY J. HOUGHTON: As a consultant to several Blue Cross and Blue Shield plans and through contact with several insurance companies with sizable blocks of group business in the 10 to 200 life class, I am aware of rather frequent severe problems with the medical insurance on the smaller policies.

The (Table 1) on the slide indicates that about 38% of the employees in the United States excluding Government and Railroad employees, work for companies who employ between 10 and 99 people. An interpolation between the brackets suggests about 30% of the employees in the United States work for companies who employ between 25 and 200 people. Therefore, it is a large market and will generate a substantial amount of medical expenses, and consequently premium dollars and can not be ignored.

TABLE 1

DISTRIBUTION OF EMPLOYEES
BY SIZE OF COMPANY
(EXCLUDES GOVERNMENT AND RAILROAD EMPLOYEES)

| COMPANY | NUMBER OF COMPANIES | NUMBER OF EMPLOYEES | PERCENTAGE OF TOTAL EMPLOYEES |
|---|---|---|---|
| 1 - 9 | 3,333,858 | 10,526,044 | 16.2% |
| 10 - 49 | 822,584 | 17,283,504 | 26.6% |
| 50 - 99 | 108,807 | 7,602,142 | 11.7% |
| 100 - 999 | 82,694 | 20,142,431 | 31.0% |
| 1,000 & OVER | 4,352 | 9,421,459 | 14.5% |
| TOTAL | 4,352,295 | 64,975,580 | 100.0% |

Many of us in the group medical field believe the largest groups are going to assume most of their own risks for medical insurance, and the traditional medical insurers will serve mainly as administrators and advisors with only a secondary role as underwriters. This leaves the groups in the 25 to 200 size classes as the remaining opportunity for group underwriting as we knew it in the 1950's and 1960's.

Why has this segment of business been unfavorable for many companies at least periodically? It is my opinion that there have been several reasons including a couple that may appear to be contradictory. In certain years adverse trends develop and costs increase more than most companies have anticipated, and the groups with losses exceed the groups with gains by a significant amount. This happens with some regularity, and a cyclical result will not be completely upsetting if the favorable experience in subsequent years reverses the losses.

However, what does upset group insurance people and corporate officers is when the company has apparently established rates that include proper trend rates and the results are still adverse.

One might ask how the trends can be proper or adequate and claims adverse in a line of business. The change in medical cost can be measured in indices, and the insurance costs for large segments can be measured so that one can feel confident that in a particular time period the cost increased at, say, less than 20%. At the same time, a company's group business for sizes 25 to 200 may have had adverse experience in spite of manual changes and experience rating that accurately reflected prior experience and used a trend assumption of 20% or more. When this occurs it appears that the company's book of business has deteriorated for some reason and antiselection has caused an unexpected loss.

It might be helpful to review the various rating systems that exist for this market segment. The (Table 2) on slide shows several models that illustrate some of the rating systems used by carriers.

Company A has standard rates for certain benefits, and for groups under 100 the same rates are applicable regardless of ages of employees, sex distribution, or experience. For groups of over 100 lives, it experience rates using a typical credibility formula, and the surplus is refunded or the deficit carried forward as the case may be.

Company B has a pool of groups which have between 10 and 50 lives, but the original rates and subsequent rates are based on the manual rates for the age and sex distribution. For 50 to 200 lives Company B experience rates using credibility formulas for the prospective rates. There are no refunds and no deficits applicable to any group. Aggregate accumulated experience of the class may affect future rates.

Company C has manual rates determined by age, sex, and area. But each group may be in the standard class , or if the recent experience is favorable in a preferred class with a modest discount, perhaps 10% to 15%. Poor experience may result in being placed in a substandard rate class with rates 15% to 20% higher than the standard rates. In the size class 50 to 100 the groups are experience rated and the non-credible experience is rated for age/sex/area. The rates are prospective only.

TABLE 2

TYPICAL GROUP RATING SYSTEMS

| | COMPANY | | | | |
|---|---|---|---|---|---|
| | A | B | C | D | E |
| 10 TO 50 | POOLED NOT RATED BY AGE/SEX | POOLED AGE/SEX RATED | "TIER" AGE/SEX RATED | EXPERIENCE RATED PROSPECTIVE ONLY NOT RATED BY AGE/SEX | EXPERIENCE RATED PROSPECTIVE ONLY AGE/SEX RATED |
| 50 - 100 | POOLED NOT RATED BY AGE/SEX | EXPERIENCE RATED PROSPECTIVE ONLY NOT RATED BY AGE/SEX | EXPERIENCE RATED PROSPECTIVE ONLY AGE/SEX RATED | EXPERIENCE RATED PROSPECTIVE ONLY | EXPERIENCE RATED PROSPECTIVE ONLY AGE/SEX RATED |
| 100 TO 200 | EXPERIENCE RATED PROSPECTIVE & RETROSPECTIVE | EXPERIENCE RATED PROSPECTIVE ONLY | EXPERIENCE RATED PROSPECTIVE ONLY | EXPERIENCE RATED PROSPECTIVE & RETROSPECTIVE | EXPERIENCE RATED PROSPECTIVE & STABILIZATION RESERVE |

Company D experience rates the groups under 100 lives on a prospective only basis. They use some credibility and judgment and for the 10 to 50 size seldom reduce rates or allow increases less than trend. For the 50 to 100 size the experience rating is rather standard with credibility formulas and prospective only rates. Above 100 lives they pay refunds based on the retention currently in effect.

Company E has an experienced rated program for groups of 10 to 100 lives with credibility using the age/sex/area manual rates for the non-credible portion. The rates are prospective only. Above 100 lives the groups are experience rated both prospectively and retrospectively, but no refunds are paid unless a rate stabilization reserve has been accumulated at a target level. Upon termination the rate stabilization reserve available is paid to the policyholder.

We have not mentioned it specifically, but most of the companies who experience rate pool claims above some level and substitute a pooling charge for excessive claims.

It is my opinion that, for groups in the 10 to 50 size range the use of age/sex/area factors for original rates and renewal rates is essential. I also believe that some type of rate variation by experience is also required. The reason for the latter is that the policyholder is almost always in a position to antiselect against the company. When his group's own experience does not affect his rate except for the barely discernible impact on the total pool he may allow ineligible people to participate or permit other infractions of the rules. However, when his own experience modifies his rates he often becomes more sensitive to abuses and cooperates better in adhering to the rules. In summary, the use of some rate modification serves two purposes. It helps encourage retention of better groups and it make policyholders aware of the costs associated with excess claims. Therefore, for the 10 to 50 size groups we would expect the system of Company A to be least successful and the system of companies C and E to be most successful.

In the 50 to 100 size group, we believe that traditional experience rating on a prospective only basis with a pooling of claims above a modest amount ($10,000 to $20,000) is the most desirable system. The use of age/sex/area factors to determine the non-credible portion is important when the group's characteristics are substantially different from "par". The credibility factor will normally be rather low on this size group (35% to 60%) and that leaves a part of the renewal to be based on the pool. Therefore, the pool should be adjusted to be similar to the group. My conclusion is that the superior technique is that of companies C and E, and the inferior technique is that of Company A.

In the 100 to 200 class with greater credibility (60% to 75%) the need for continuous age/sex data is reduced. The problems we see in this size band are the lack of margins provided in the rates and the excessive credibility applied to the group's recent experience.

The next slide shows a distribution of results generated by a Monte Carlo simulation for groups with exactly the same utilization characteristics, so the distribution represents random fluctuation entirely. If one accepts this type of distribution as valid, one comes to several conclusions. One

is that on underwriting a new case based on favorable experience from a previous carrier too great a reliance on extremely favorable experience may lead to an inadequate rate because such low claims in a year are very frequently a fluctuation.

The (Table 3) on this slide indicates that for groups with 100 employees, over 40% have a claim rate in a year that is less than 80% of their true expected claim rate. For groups with 200 employees, approximately 30% have a claim rate in a year that is less than 80% of their true expected claim rate.

The results of this distribution and the manner in which some companies operate is that many groups are issued at inadequate rates or renewed at inadequate rates because of excessive credibility applied to short-term favorable experience.

The inadequate margin problem is most evident when retrospective systems are involved. Using the information from the slide, one can see that many groups will have favorable experience and receive significant refunds. However, those groups with unfavorable experience are frequently going to exceed the normal margins and be in a deficit position. For a 100 employee group, only 7% of the unfavorable groups are in the 100% to 110% range, and 26% have losses in excess of 10%. Therefore, even with a 10% margin, there will be a significant number of groups with a deficit even with a margin as large as 10%, which is probably as high as possible in a competitive market.

When the rating is prospective only, the problem is solved by the gains offsetting the losses. When the surplus is retained by the company in a rate stabilization reserve up to some level consistent with the size of the group, the carrier has effectively increased its margin before any refund payments are made.

Obviously, for the larger groups the change in distribution helps with this situation, and retrospective rating is much more feasible.

Looking again at the slide for the various companies, I believe that companies B and C are most likely to be successful, followed by company E, and companies A and D having potential problems.

At this point, we have not discussed the general inadequacy of rates based on changing technology, higher than expected trends, outside economic influences, etc. They are also a problem.

In summary, we see some average groups with average expectation which have had a short-term favorable experience receiving unduly low future rates leading to a greater future risk. On the other hand, groups with average expectations which have had adverse short-term experience may be charged a redundant rate leading to a termination. This is especially true when there is retrospective rating and a deficit must be amortized before refunds are paid.

The establishment of an effective rating system is difficult and success is not guaranteed, but I believe the starting point is to avoid procedures which almost have to result in unfavorable results based on antiselection and the ability to move rather freely among carriers.

TABLE 3

DISTRIBUTION OF EXPERIENCE BY GROUP SIZE

PERCENTAGE OF GROUPS BY ACTUAL/EXPECTED RATIOS

| | GROUP SIZE - EMPLOYEES | | | |
|---|---|---|---|---|
| | 50 | 100 | 200 | 500 |
| **NO SPECIFIC STOP LOSS** | | | | |
| UNDER .60 | 17.0% | 6.7% | 2.2% | 0% |
| .60 TO .80 | 33.4 | 35.0 | 26.4 | 13.7 |
| .80 TO .90 | 13.8 | 15.7 | 21.4 | 22.0 |
| .90 TO 1.00 | 8.0 | 9.6 | 11.8 | 17.7 |
| 1.00 TO 1.10 | 5.7 | 6.8 | 9.4 | 21.4 |
| 1.10 TO 1.20 | 3.1 | 4.2 | 8.0 | 11.0 |
| 1.20 TO 1.40 | 5.2 | 7.3 | 8.4 | 9.7 |
| 1.40 & OVER | 13.8 | 14.7 | 12.4 | 4.7 |
| **$30,000 SPECIFIC STOP LOSS** | | | | |
| UNDER .60 | 17.0% | 6.7% | 2.2% | 0% |
| .60 TO .80 | 33.4 | 35.3 | 29.2 | 22.0 |
| .80 TO .90 | 13.8 | 18.5 | 28.0 | 39.3 |
| .90 TO 1.00 | 8.5 | 13.5 | 18.6 | 26.0 |
| 1.00 TO 1.10 | 6.6 | 9.1 | 13.4 | 12.0 |
| 1.10 TO 1.20 | 5.8 | 7.1 | 4.8 | .7 |
| 1.20 TO 1.40 | 8.1 | 7.1 | 3.8 | 0 |
| 1.40 & OVER | 6.8 | 2.7 | 0 | 0 |

MR. HAUSER: The next two presentations will be from specific companies that have their own systems. Ron is going to talk first and tell us about the Travelers' system and how they rate these plans.

MR. RONALD W. VERNIER: At the Travelers, we have a specialized book of business for 50 to 150 lives for a full health package and for up to 1000 lives for single sublines, such as, drug, vision and major medical only. This class of business which, currently represents about 2,000 cases generating nearly $200 million of annual premium, melds the small non-rated book with the larger retroactive rated book. We have termed this class of business PRO (Prospectively Rated Only). We continuously modify benefits offered to the small to medium size group market to keep pace with the benefit trends evident in our industry. Our marketing strategy for this size market has called for offering a full line of high quality benefits with considerable tailoring of plans under a fully insured program.

The small-to-medium size group market is unique in that the advance rates are set reflecting case experience even though the individual policies are not retroactively rated. Although actual case experience is reflected in the advance rating process, the case size is such that actual experience is not entirely credible and, therefore, the manual has an impact in setting the advance rate level. Obviously, the larger the number of insureds, the more credible the case experience. The credibility applied to actual case experience varies from 40% at 50 lives to 100% at 1500 lives for a single subline plan. A plan with full health benefits varies from 60% credibility at 50 lives to 100% credibility at 750 lives. Since the cases are not subject to retroactive rating, no margin is required in the advance rates.

The underwriting of new business prospects is done primarily in the field. Conditions that require home office approval include:

1. The case is presently insured through another carrier on an experience rated basis so that prior experience can be evaluated.

2. The case has not been previously experience rated, but:

   a. develops a rate which is less than that charged during the latest policy period for comparable benefits;
   b. the health package to be written provides significantly greater benefits than those presently in force.

3. Risks with marginal employment, high turnover, high benefits, or high contributions which do not meet minimum requirements.

4. Certain industries such as furriers, restaurants, hospitals, government units, public transportation, or other groups which may produce unusual experience.

5. Groups involving special coverages, such as, LTD, creditor, and any non-standard coverages.

Virtually all other quotations on full packages may be made in the field without initial referral to the home office.

On those cases presently insured through another carrier, we require a booklet, certificate, or policy describing the plan of benefits (including any benefit revisions). In order to properly assess our initial liability, we require a description of extended benefit provisions and all data pertinent to the evaluation of the prior experience. The purpose of evaluating transferred business is to help achieve a long and profitable relationship with an insured through competitive quotations consistent with sound underwriting.

Final home office approval is still required for cases with at least 100 lives for a full health package and with at least 200 lives for specialty lines, such as, prescription drug, vision, weekly indemnity and long term disability. A dental only quote may be made in the field on cases with less than 500 lives.

Initial rate guarantees for all quotations are limited to 12 months from the effective date of coverage although a 16 month rate guarantee is available in the first year at a slightly higher price. A large number of the prospects do not have experience available for evaluation and, therefore, are quoted at manual adjusted to reflect the level of expenses associated with the size of the group.

Specialized units have been developed to handle the PRO cases: New Business, Renewal Rating, and Underwriting. All quotations even those done in the field, are submitted through the New Business Unit, and it is their responsibility to see that a case is properly placed. On each PRO case, the Rating Unit assembles the renewal experience used to set advance rates and to accumulate financial statistics. The Underwriting Unit is responsible for servicing the risk, including placement of renewal rates. The use of specialized units not only helps to control expenses, but provides a means to determine actual expenses incurred.

The financial results are closely monitored on this class of business. A major portion of the PRO rating process is automated, and financial results are accumulated automatically. Premiums and claims are identified for PRO, and the monthly loss ratio development is monitored. This provides a base to analyze the current experience and trends. We have recently seen a deterioration in the financial results for our PRO business. An analysis of the reasons for this deterioration showed that it was primarily the result of extraordinarily high rates of medical cost inflation and utilization for this book of business that had not been anticipated in the underlying expected experience. In addition, certain expenses had increased more than expected for this business. The following corrective actions were recommended:

1. Adjust the non-credible portion of prior experience to reflect the actual rate of inflation.

2. Streamline the benefits to help reduce required expenses while still meeting customers needs.

The first corrective action was accomplished by revising the advance rating formula. The second was accomplished by shifting the emphasis from tailoring of plans to pre-packaged plans of benefits where rates are determined by a computer program. We continue to offer tailoring, within the framework of our product line, to meet specific customer needs at a

slightly higher cost to cover the additional expenses. We have not revised any underwriting guidelines or made any changes in the guarantee period of the rates. The corrective action has been recently taken, and the impact on financial results will not be known for some time.

Although flexibility for renewal negotiations exists, a reasonably strict discipline is maintained. Normally, higher rate increases are the result of poor case experience and, since the advance rating process reflects the actual case experience, the need for the increase can usually be demonstrated.

The recent emphasis in the marketplace has been to extend alternate funding schemes to the smaller risks. Although the added expense of banking arrangements and administration tends to offset any premium tax savings on this size case, we will offer alternate funding arrangements on cases with at least 150 lives in the near future.

MR. HAUSER: Now, Henry Essert will speak from the point of view of Crown Life where this product is their primary group product in the marketplace that they are serving.

MR. HENRY ESSERT: The subject of this session is the small-to-medium size group market. To lend some perspective, it is instructive to note that in 1982 this market was composed of 350,000 employer units and 22 million employees, almost 1/3 of the labor force. Assuming $1000 annual health premium per life and 50% penetration by Blue Cross, then insured, non-Blue Cross premium income in this market exceeds the total 1982 premium income of the 5 largest group carriers. By any measure, we are talking about a big market.

The program outline for this session provides a good guide for discussion. This being the case, I would like to follow it in my remarks, except to change the order somewhat.

Let us address the most important point first.

Is this market a profitable one? Yes! If you do it right.

Doing it right means many things, but fundamentally and simply it means exercising control over the 3 basic quantities in the income statement: premiums, claims and expenses.

With this in mind, let us consider the other points in the program outline.

What has been the impact of recent financial experience on underwriting and selection practices? It is important to remember that the advantages of selection are inversely proportional to the credibility assigned. In the small or pooled group area, selection and underwriting standards are the primary control mechanism. Selection determines the makeup of the pool of business which, in turn, determines the premium. The trend is clearly towards conservative underwriting despite the reduction in potential market that this strategy effects.

What has been the impact of recent financial experience on benefit design and rate guarantees?

Two years ago, 12 month rate guarantees were standard, 24 month rates were not unheard of. Now rate guarantees of six months or less are common. In an environment where medical care cost trends are unpredictable and out of control, the ability to react quickly and decisively must be maintained.

By contrast, benefit changes have been slow to gain market acceptance. The $100 deductible, 80/20 plan is still the standard despite the fact that $100 today does not buy what it did 5 years ago especially, if what you are buying is medical care.

What are the techniques for monitoring financial results? That we need to assess experience by geographic location, plan design, and source of business is obvious. Perhaps less obvious is the need to assess the overall experience of the pool and such other segments as they relate to the variations in prospective and retrospective rating techniques. Such overall assessment provides a control of the rating techniques, but perhaps more importantly, a control of the expense component of the income equation. In the small to medium market, expenses are a proportionally larger share of the premium. Initiatives to reduce costs and improve productivity can generate significant competitive advantages.

It is essential that service be provided on an effective and efficient basis. The days when budget overruns could be passed on to the consumer are over, and rightfully so.

How much credibility should be given to individual case experience? This is an interesting question. In the 25 to 200 live range, we span the spectrum from none to 100%, at least with regard to medical coverage. There are many ways to determine the mathematically correct credibility level. Because of its simplicity, I prefer the empirical approach. By observing the experience of a sample of like size groups over 2 years, a scatter diagram can be constructed. In simple terms, the slope of the regression line through this diagram is the credibility level.

Regardless of which mathematical technique is used, the process of determining the correct level cannot stop at the mathematical answer. It is far more dangerous to be out of step with standard market practice than to be mathematically incorrect.

How have insurers handled outsized rate increases? On the whole, very badly. The definition of an outsized rate increase has much in common with the concept of inflationary expectations. Ten years ago, I suspect a 15% rate increase would have been considered outsized.

In a renewal, where benefits remain unchanged, the rate increase is a combination of underwriting error and medical care trend. Underwriting error, because, even if the insurer does not seek to recover past losses, the rate level must be moved to the correct prospective basis to avoid future losses. Compounding this realignment with ever-present inflation produces the so-called outsized rate increase.

The misunderstood component is the assumption that benefits have remained unchanged. In an environment with 20% inflation, continuing with a $100 deductible, represents, in real items, a benefit increase. On the whole, insurers have not given this fact fair hearing in handling outsize rate

increases. This is not surprising, if you consider that by not adjusting benefits in an inflationary environment, we are selling more to the same customer. Is there a market for partially self-funded plans? While traditional PSF plans (that is, employer funding between the employee deductible and a defined specific stop loss level) appear to be losing such popularity as they once had, minimum premium and similar retrospective arrangements are creeping as low as 100 lives.

To the extent that such arrangements are inherently sound, they represent a reasonable alternative to traditional fully insured plans. The problem is one of adequate understanding rather than inherent soundness. Such arrangements have at their core, a realignment of risk. It is incumbent upon us as insurers to explain the potential impact of such realignment. The customer must be aware of what he is giving up in return for potential premium savings.

I would suggest that our need to provide such disclosure and education has a more pragmatic end than simple fair play. In the coming era of financial deregulation and the resulting free-for-all, our competitive advantage as insurers may rest largely on our expertise as risk managers.

What has been the financial impact of cost containment provisions? There are numerous studies which calculate the claim reductions realized by second opinion, same day admissions, ambulatory surgery etc. The cost savings realized by these provisions vary in degree, but the overall consensus is favorable.

Despite the premium reduction that such claim savings generate there is considerable reluctance particularly at the smaller end of this market, to implement programs which radically alter the standard $100 deductible, 80/20 format. But this reluctance is waning.

The most interesting aspect of cost containment is the clear indication that insurance companies, through benefit configuration, can exercise significant control over the health care habits of the population. While an increased awareness of wellness and the impact of lifestyle on physical well being is clearly a general trend, it is gratifying to think that the insurance industry can foster this trend by appropriate benefit design and heightened client awareness.

To sum up, the recent history of the small to medium size group market has been characterized by a trend towards conservative underwriting, a drastic change in attitude toward rate guarantees, greater attention to cost reduction and productivity improvement methods, greater focus on the marketplace, and gradual emergence of retrospective funding arrangements. These trends have direct impact on the three basic quantities in the income statement -- premiums, claims and expenses. And since, as I stated earlier, the key to this market is the exercise of control over these three basic elements, I would conclude that these trends are evidence of our industry's collective effort to make a profit in this marketplace.

In short, is this market a profitable one? Again, yes if you do it right. Thank you.

MR. HAUSER: Thanks, Henry. I would like to open it up for audience participation. As I said, this is an open forum. We are hoping that we will hear some questions or comments, remarks by many of the other companies that are represented here. MR. KERRY A KRANTZ: The reluctance to go from the $100 deductible, 80/20 plans is two-fold. One, it is what everybody is selling and there is a reluctance to change. But, two, there is also a larger premium and commission, I would think, under the current basis for the broker or agent. Is there any company here or that is known about which is grading their commission patterns so that more would be paid on a less rich plan in order to attract the broker to try and push that kind of a plan?

MR. ESSERT: Yes, I will just say we at Crown have not done that. We are seriously considering it though. We have experimented with a number of situations, and we are not intending to pay a different commission schedule on a higher deductible plan, but rather to adjust our schedule and the grading in such a way that there is not as significant a disadvantage to the broker when selling them.

MR. HAUSER: I just might mention that at Metropolitan we have a sales force which is dedicated to this particular marketplace, 50 to 200 lives. We do not pay different commissions based on what they sell, although we have different plans that are available. But sales managers' compensation is, to some extent, based on the profitability of the block of business that they and the people under them sold. They are very aware of which plans are easier to underwrite and, therefore, easier to make a profit on. So, they sort of have a profit element in their total compensation package, and it can be significant. It can add up to quite a bit of money if they are very profitable.

MR. RICHARD B. SIEBEN: I am aware of three carriers which I am not really free to identify who have used a system like a different commission schedule where they have dealt with per capita commissions so that effectively the commission is exactly the same on a $500 deductible as it is on a $100 deductible. In all three instances, that strategy was chosen where they were pushing partial self-funded products, and they wanted to essentially hold the agent harmless for introducing the $500 deductible back to the employer. You get what you pay for, and there was a strong incentive there where they wanted to create higher deductibles that were consistent with their marketing strategy. I agree with what Mr. Essert said in terms of the lack of enthusiasm in the marketplace for changing from the $100 deductible as the standard. When you talk about an 80/20 coinsurance, the thing that dismays me most is (particularly at the small end of the market) the out-of-pocket maximum phenomenon, the $1,000 caps, and things of that nature. If we look back 25 years ago, as a few of us in this room still can, and we dealt with the first comprehensive major medical products even on a large group, we are maybe talking $25 deductibles and 75/25 coinsurance up to a $5,000 or a $10,000, say, annual maximum. In that period of time, the deductibles inflated four times, but the out-of-pocket at that point was $2,500 plus anything that the insured had over $10,000. Today, we are stuck on the dime and encouraging very low, (say, 20 percent of the first $2,500 out-of-pocket), and that is the part of our equation and standard product that is biting us much more than just the deductible by itself.

MR. HOUGHTON: I would like to comment on the general subject of how you treat some of these benefit differences. In a number of cases people were looking toward the rate structure to make it more desirable to go to the higher deductible, and they did not see that much difference between the $100 and $200. Rather than encourage the agents to sell the $200 by paying higher commissions, they actually surcharged the $100 plan by a few percentages. So, instead of having a difference of 8% say between the $100 and $200 deductible, they forced the difference up maybe 12% or 13%, and we have done the same thing in some of our manual ratings. We have a feature that pays 100% after $2,000 to $2,500. We surcharged that versus paying 100% after $10,000 because we think there will obviously be some problems. A person who is in the hospital four or five days and has run through his 80% corridor, has no financial deterrent from staying a little bit longer, whereas the person who still has to pay 20% up to $10,000 may want to get out of the hospital a day or so earlier. So, I think that one thing to do is to surcharge the ones you suspect will have worse experience.

MS. ROBIN J. KAVALL: I would like to ask either Mr. Vernier or Mr. Essert if either of your companies have ever analyzed first year results on business taken over from Blue Cross and Blue Shield. Very often, the nature of the contractual agreements with local providers, physicians as well as hospitals, allow groups to enjoy substantial differentials on full service benefits. My guess is that the loss of these differentials is often not adequately reflected in the commercial transferred business analysis.

MR. VERNIER: No, we have not analyzed that experience. Our underwriting procedures, however, are such that there are very few Blue Cross cases we actually take over.

MR. SANFORD B. HERMAN: I heard one individual talk about introducing cost sharing at the back end of the hospital stays. We have traditionally sold a 100% contract, and what we decided to do as one of our cost-containing policies was to introduce front end deductibles in the hospital. In particular, something like $50 a day for the first seven days. In this way, we felt that we could encourage outpatient utilization for the less serious illnesses, and we have had fairly good success in selling this in the Midwest. In particular, in one metropolitan area we put a fair amount of this on the books. The other comment I wanted to make, is that we have been operating with traditionally something like 25 or 30 regional group offices, and we have treated each of them as a separate profit center. As Metropolitan does, our base compensation for new business is affected by the profitability of the office both up and down. So, while we have rewards for profitability, we also have penalties for unprofitable business. The other thing we do is to bottom line each office's experience to determine the manual rates to be charged. Probably the biggest penalty is not the effect on the bonus of an unprofitable book of business, but some severe rate actions which can, in essence, close down an office for a fair amount of time. I wondered how many other companies are bottom lining their offices for purposes of determining the manual rate.

MR. HAUSER: I might mention that at Metropolitan we do have area rates and we do look at the experience by region. The effect is that we do not, perhaps, bottom line it, as you call it, but the area rates are affected by the experience of the groups that are sold in that area. So, I think the effect is really the same, and you can put someone out of business for a while if the experience is very bad.

MR. ROBERT F. CARBONE: We do both those things. We have a profitability adjustment in our group sales bonus formula which is either an up or down adjustment, and we do bottom line the results for each of our regional group offices for their various lines of business. Yes, we have put some of our group offices out of business for extensive periods of time.

MR. ESSERT: I have a comment on that. The idea of putting a group office out of business is something that we gave up a while ago. Our strategy as far as the rates are concerned is that the rates, regardless of the capability of the underwriter, will always be set at a market level. We look to see if the underwriters -- I say underwriter because we allow our Group Sales force to underwrite, and we give them complete authority for business up to 50 lives -- have written profitable business and whether they apply the underwriting rules consistently. If they do not, we terminate them; we do not increase the rates in that area. We bring someone in who can do the underwriting properly, or we adjust the underwriting standards to meet our sales and profit objectives.

MR. MARK A. CHESNER: It was mentioned that many of these plans are sold as package deals for simplicity. I wanted to ask how that squares with minimum state mandates for benefits such as out-of-hospital psychiatric which might not equal the assumed benefits you put in. Do you simply use it, or do you actually adjust it for the different areas for different state mandated benefits?

MR. ESSERT: Depending on what the minimum state mandate is, for the majority of them we have about six plans that we offer to groups under 100 lives. Each of those is varied by state if there is a state variation. If the state requirement is too stringent, we will not do business in the state.

MR. HAUSER: Tony, do you have any experience in that area as to what your company is doing by state?

MR. HOUGHTON: No, except we will comply.

MR. HAUSER: Does Travelers use the SIC codes?

MR. VERNIER: Yes.

MR. ESSERT: Crown does it.

MR. HAUSER: I do not know whether we use the SIC codes, but we do have industry classifications certainly. They might be our own as opposed to perhaps the SIC codes.

MR. JONATHAN ROSENBLITH: I hear a lot about Crown's competitive rates from our sales force. I do not hear much about their underwriting restrictions. Specifically, we have a lot of proposal activity. We like to do our underwriting on the front end if at all possible, and one of the things I hear a lot from my sales force is that Crown tends to do it on the back end. They will put out a tentative proposal saying if you can give us this information, and if it looks like this, here are your rates. I wondered if that is true, and also as much as you could tell me, the types of things you would require. I am looking at how cost effective it is to generate a whole

bunch of proposals. Do you have any guidelines to restrict the type of proposals you would get?

MR. ESSERT: We use the term back end underwriting for something different. We underwrite the case on renewal, and we do not ask for the same type of information, but we go over that information again and sometimes refuse to renew the case, essentially. At the front end, we have started with two approaches. One approach is the one you mentioned which is basically that we send out what we think are competitive rates, and we say that these rates are good if the following information is submitted and subject to our verification and analysis. The other approach we tried was essentially not to provide rates until such time as we receive that information, and we are able to assess it. I am having difficulty deciding which of those to continue. We tried both of them as a test, and they both worked quite well. It all depends on the location. It depends on how well known we are in the marketplace. Where we are very well known, we do not bother sending out the rates; we basically ask that they send us the information. In terms of the cost effectiveness, we have a proposal mill. We have a very efficient means of calculating rates and distributing the information. I do not recall any of the particular underwriting questions.

MR. ALAN N. FERGUSON: A question on underwriting to Mr. Essert. I think you said that you reject about 50% of your cases which seems a very high proportion to me. At the smaller end of the scale at the Prudential, I believe the figures may be something like 30%, but that is more towards the 2 to 9 life group rather than the 10 life and over. One of the most effective ways to select cases or to eliminate poor business, is to do a lot of calling of employers and find out if the employees are really genuine employees. Are there more employees than have been listed in the proposal, and so on? Are you doing anything like that, and could you expand on the 50% rejection rate? What reasons are there for turning down that number, and how do you do your underwriting?

MR. ESSERT: In terms of the percentages, when we set the product up, we intended to decline about 40% of the business. That was our target. We established underwriting guidelines, measured it against our book of business and external indicators at the time and felt that that is what we wanted to accomplish. When we put it in the hands of our sales force, they actually declined a bigger percentage than that. That is how we have gotten to the 50% range. As to your comment on inspecting the business, we have found that our most successful underwriters actually visit the employer. We have found that not getting sufficient premium is almost as big a problem as getting the wrong types of claims. We go to great lengths to determine his actual work force complement and we require 100% participation. We have guidelines as to how many part-time people we will allow in the group because we have found that part-time people tend to become full-time people if something goes wrong, and problems like that. So we do put a great deal of emphasis on that.

MR. HAUSER: Do you do the billing yourself? Do you have the inforce and do the billing?

MR. ESSERT: Yes we do.

MR. HAUSER: How about you, Ron, do you do the billing yourself? Do you have the inforce, keep the inforce up-to-date on this size group, and then bill?

MR. VERNIER: Yes, I believe so.

MR. HERMAN: With respect to the billing, one of the things that we have found recently is cases which are called noncontributory and supposedly have 100% participation are not turning out that way. Employers are allowing certain employees to opt out, typically where you have two wage earners in the family. As a result, we are getting less premium and experiencing less coordination of benefits (COB) savings. I wonder whether other companies are finding that to be a problem.

MR. HAUSER: Does your company keep the inforce on these cases?

MR. HERMAN: Yes, our home office bill groups up to 75 lives. I guess the problem is probably at installation with respect to willingness to allow employees to opt out.

MR. HOUGHTON: Do you know that they are not there because of life and weekly income benefits?

MR. HERMAN: There are waiver cards that are typically used for contributory cases, and they are showing up on the noncontributory cases as well, mainly in the major medical area.

MR. HOUGHTON: I personally have talked to many clients, and I feel strongly that you ought not to allow waivers on employee coverage. But, you ought to allow waivers on people who do not want covered dependents where dependents are working, and that is a little stronger than the industry standard. But, I think if it were generally the industry standard that all employers would be expected to cover their own employees, it would be a good thing. For an employer who does not, that employer would still have to meet the 75% requirement with those people.

MR. HAUSER: A number of years ago we did a little study, and we found that in those areas where there was a very small dependent ratio, we were having much poorer experience than in areas where we had a higher dependent ratio. Our rating system takes that into account.

MR. SIEBEN: There are six or seven states now that have health maintenance organization (HMO) penetration in the total market between 10% and 20%. With that kind of penetration on a given case, even within this range (your 100 to 250 life case), you could have, on a specific case, perhaps 15% or more penetration by an HMO. I am curious as to whether there are any particular underwriting recognitions of that kind of penetration on a case-specific basis. Particularly since that penetration (when it is there on a specific case) is likely to grow over time. You will have declining enrollment, so you will have the problem on a takeover piece of business of getting the census on the people in the traditional program for establishing your group rate, but not getting it on all employees or all insureds, since some of them are not going to come to you. Do you have any particular ways you take HMO participation into recognition on a case basis?

MR. ESSERT: We take it in very, very simply. We have a maximum HMO participation that we will underwrite. I am not familiar with exactly what it is.

Back to the other question of participation. Again, we found the very important component is to get the correct number of participants, so we have experimented with a number of things, and maybe somebody here from California can help me out. There is a Department of Labor requirement that an employer in California submit quarterly statements as to the number of employees. I am not sure what the term for it is, but we have experimented with using that on our smaller business -- the 2 to 9 life -- and have found it quite successful. We ask the employer to send us a copy of that every once in a while, and then we verify it against his billing. We have not tried it on the larger businesses.

MR. HAUSER: I do not believe that we -- Metropolitan -- have any restrictions regarding HMO participation. We might have some overall restrictions regarding participation which would take that into account, but I do not think HMO's are specifically identified as a separate category of participation.

MR. LESLIE STRASSBERG: I would like to address the issue of long term outlook for this market. Cafeteria or flexible benefit plans are becoming more and more prevalent, especially in the larger employer groups 1,000 lives and up. I venture to guess that as time goes on, these cafeteria style benefit plans, allowing flexible choices to employees, will become more and more prevalent in the smaller group marketplace, especially in the 25 to 200 life range. My question -- which is directed to anyone in the room who cares to answer -- is how the insurance industry will deal with the flexible choices that will need to be offered to employees to accommodate this type of cafeteria benefit plan.

MR. ESSERT: My only comment would be that I agree with you. I think the flexible benefit or cafeteria approach is very definitely the wave of the future. I think certainly from Crown's perspective, we would not intend to get into the market in the under-100 life business for quite some time. We would be looking to gain experience in a retrospective environment in the larger size (100 to 500 life market) first to determine what the results of antiselection could be to determine a fully insured price for it. The future of that, I think, has a lot to do with the cost of medical care escalation. In my opinion, the cost shifting that we have seen in the past is going to be mild compared to what we are going to see in the future. So, that is very definitely going to cause an increased medical care cost trend. I think a very good solution to it for the employer is to put in place some type of flexible benefit plan. So, there will definitely be a desire to have that.

MR. HAUSER: I personally feel that it is going to be a while before it hits this marketplace, but I do agree that this is the wave of the future. I have noticed that the smaller groups tend to follow the larger groups because it becomes the "thing". Even if it does not make a lot of sense for them, they still want it. I think minimum premium, for example, down at the smaller end of the marketplace, does not make a lot of sense from a financial or any other point of view, yet there are many small employers and brokers that are out selling it because that is what the big guys have, and so they want it also. If that is what they want, insurance companies are going to give it to them, I am sure.

MR. ESSERT: Does anyone sell flexible benefits in this marketplace?

MR. HAUSER: I guess it is not here yet. Has anyone seen any tendency toward self-insurance in this marketplace?

MR. HOUGHTON: Sure. We see a lot of semi-self-insurance, where people will deal with an administrator. They buy a $1,000 deductible plan, but in fact the administrator is handling benefits at 80% over $100. In effect, the employer is paying the cost between the $100 deductible and the $1,000 deductible that he has purchased. And, we see people selling them aggregate stop loss on the employer's maximum liability for that segment from $100 to $1,000. So, we see a lot of tendency toward that on even the very smallest size groups.

MR. FERGUSON: On flexible benefits, I really do not see it for a long time. I think that it is too complex for the small employer to handle a large variety of options. I think that you may have a high/low option for medical benefits, but the other things like baby care and whatever, I see as a long way off, if ever. One of the questions on the outline of the program is "Techniques for Monitoring Financial Results," and I wondered if anyone would like to comment on what techniques they use, through the year, or six months, or whatever? If you have a loss ratio, "quick claims," shortly after the case has been written, monitoring the number of claims cut back by COB or pre-existing, or anything else like that?

MR. VERNIER: As I said, at the Travelers, most of our advanced rating on this size group is on a computer. As a by-product, we capture a lot of statistics, including the premiums, the claims, the expenses, and this data we then feed to our statistical systems. At the same time, on a more current basis, we identify the premium and claims, and so we can get a monthly loss ratio right up to date. So, you can monitor it month-by-month. For COB, I am not too certain. I think they have some special studies for that, but that is not part of one of the by-products of the system.

MR. HAUSER: We get month-by-month loss ratios before the end of the following month. In fact, a couple of weeks into the month, we have a pretty good idea of the loss ratio. Then, we get a final one, month-by-month, before the end of the following month. We have it broken down by region -- those are paid loss ratios -- and we develop incurred ratios for the total block of business. We have standard formulas for getting incurred loss ratios, but we adjust that by the claim backlog in our claim offices (we have a fairly decent idea of our backlog because we only have, I think, two offices now that pay these claims). This particular product is a separate line of business for us, all under one person, who runs the line. Our accounting system takes the premiums, claims, and the expenses and breaks them out. He is in charge of the marketing, the administration, the pricing, etc. So, he gets a report very rapidly each month on just how we are doing on that line of business. There are supplementary reports (which are not part of that system) on COB savings and other types of management reports. But, we think we have an excellent reporting system, and it is pretty quick also. Because again, everything is underwritten right off our computer, it is easy to get to. It is not very expensive either.

MR. PIERRE SADDIK: I would like to address a question to one of you in front or maybe one of the other insurers. The specific subject is group

underwriting. To what extent is the issuance of a proposal for less than 200 lives computerized, and how long does it take to issue it?

MR. ESSERT: For our business, under 100 lives, it is completely computerized. The turnaround is in a day, I guess. For over 100 lives, we are just rearranging our procedures in that marketplace. We are going to be adopting something that we loosely refer to as the "Chinese Menu" approach, where you can take one from column A and one from column B. Right now, it takes us in the neighborhood of weeks, I imagine, to issue a proposal in that market segment because we do not have a well-defined benefit design requirement in that segment. When we do, we expect to have it computerized as well with probably a day's turnaround.

MR. HAUSER: I just might mention that we have computerized the 50 to 200 life market. We have terminals out in the field in selected places; I do not know how many. And, they just punch in the information, and they get the numbers back. As for the proposal, I am not exactly sure how long that takes, but the numbers come back overnight, I believe.

MR. JOHN A. FESSENDEN: I sense that all the remarks this morning are applicable to the operations in the United States. All three companies represented on the panel are active in the Canadian market. Would you care to comment on the applicability of your remarks to the Canadian market and describe your approach to it. Are they different?

MR. ESSERT: We operate separate divisions for Canada and the United States, so I am speaking from my peripheral understanding of the Canadian operation. Basically, they break their market down from 2 to 35 lives and then from 35 to about 150 lives. Interestingly enough, what they use, in both of those marketplaces (particularly the smaller one), is one of the types of rating that Tony had mentioned. They essentially put the business into better-than-average, average, and worse-than-average. And based on where they fit into these categories, we give them a rate. So it is a banded rate structure. I believe the renewal is done similarly, although the structure expands to 5 bands from 3. I find that the Canadian marketplace that I used to work in is much different than the American marketplace: the competitive situation is terrible. I was never able to figure out what the right rate level was in Canada. The credibility takes on a completely different tone in Canada. Investigations that we have done lead you to some very strange conclusions. For example, on some of the Extended Health Care benefits or EHC (a wrap-around of provincial plans) I found the credibility to be higher than for major medical in the United States, even taking into account some of the stop loss claims. We found that there are more claims and, therefore, the credibility is higher. I guess that is about the extent of my knowledge of our Canadian operation.

MR. HAUSER: Of course, the product is entirely different. The medical care is a much smaller proportion of the total package that you are selling. In the United States, it might be 80% or 90% of the premium, in Canada it is 20% to 25%, and you have the disability and life insurance picking up the rest.

MR. VERNIER: At the Travelers, the Canadian operation is a separate profit center, and they determine their own underwriting, and the whole thing. They have their own actuaries, and they do not consult us as to how to do it.

MR. HAUSER: Does anybody want to comment on the lapse experience in this area? Our experience has been that there is a much higher lapse rate in this area than in the over-200 life, certainly. My rule of thumb is that you get a 1% lapse for each 1% premium increase. If you are going to have a 30% premium increase, you are probably going to lose about 30% of your groups, and if you get to 50%, you are going to lose half of them. But, as I said, that is a pretty rough rule of thumb. Does anybody have any comments on what they have seen as far as the churning in this marketplace?

MR. VERNIER: If my memory is correct, for years and years, our lapse rate was running pretty close to 15%, year in and year out. And, the new business was running slightly higher than that, so the book would gradually be increasing. But, recent statistics seem to indicate that the cancellation rate has been creeping up. I do not know what the number is, but it seems to be higher.

MR. ESSERT: I think the 1% correlation is probably a pretty accurate rule of thumb. However, as I think I mentioned before, in our smaller case market, we make a conscious effort to have the premium structure marketable. With that, I guess we are experiencing lapses in the neighborhood of 10% to 15% every six-month period. Most of that lapse is our own doing, however. So, the actual lapse at that time, we feel, is not so much because of the premium but because the business just naturally churns. We found that every time you give a rate increase, the cases shop. I think we are our own undoing with the ability to churn proposals out very quickly because it has now become very simple for a broker to -- with a phone call -- get six companies to put a quote on the piece of business. We never pretend to be the lowest in every situation. In fact, I have always told the sales force that give me any case in any location, and I can find you a lower rate. It always works. I always find a lower premium than ours.

MR. JOSEPH J. BUFF: About a year ago, I started working on an earnings model, and one of the things I took a look at was the relationship between rate increases and lapse rates. Actually, we have two blocks of business that we track separately, one of which is "baby group", which is 9 or fewer lives, and the other is what we call "true group", which is everything else (which for Guardian is primarily cases under 100 lives). We also looked at the true group cases split down by comprehensive versus supplemental major medical. We found that, very surprisingly, over a four or five year period (which includes different pieces of the economic cycle -- rate increases of 10% up to almost 50%) that there was a remarkably good statistical correlation between the rate increases and the lapse rates. You are talking about 80% or 90% or 95% over that entire period of time. Now, I will not go into exactly what the parameters were, but we found a few things. First of all, the $a + bx$ formula, where $x$ is the rate increase. We interpreted $a$ to represent business failures primarily and a few other factors. We found that a was about 50% higher on baby group cases than on true group cases, which to us made some sense because they are probably much more prone to business failures. As far as b, which I guess you could call a "shock" coefficient, we found that the true group cases are about 30% more sensitive than the baby group cases. So, looking at the two together, it says that the baby groups tend to be more subject to an underlying, relatively constant rate of business failure, which causes us to lose the case. But,

they seem to be significantly less sensitive to the rate increase itself, which is kind of appealing, I think.

We took a look at the true group cases, comprehensive and supplemental split separately, which to us are sold in different geographic sections of the country (supplemental is sold mostly in the Northeast). We found that the rate of underlying business failure on true group cases was identical and that the comprehensive cases seemed about four times as sensitive to the rate increase as the supplemental cases were. And again, it seemed to make some sense, based on our understanding of competition, the nature of the different cases, and the fact that between comprehensive and supplemental, the demographics by size may be relatively comparable in different parts of the country. I would just repeat the first thing I said: we were really quite surprised to find that this relationship works so well over the whole four-year period. We never really looked at it before, and needless to say, we are using it in our new earnings model.

MR. CHARLES T. DOE: The lapse rates study which I did in 1982 pretty much confirmed the 1% relationship. One of the things that we have noted is that there seems to be a pattern of cancellation not at the anniversary or right after renewal, but during the year. We specifically studied first-year cases where approximately 20% of the lapses -- either during the first year or after the first renewal -- actually occurred before the eleventh month. This caused me to wonder whether or not the company's age/sex relationships were changing during the year to the extent that it was so beneficial for them to change carriers. I wonder if there could be a show of hands as to how many companies here would use age/sex specific rates over 15 lives?

MR. HAUSER: Let the record show that a lot of companies use age/sex specific rates over 15 lives.

MR. DOE: How about over 25 lives?

MR. HAUSER: Let the record show it is a pretty good number there also.

Do you give one-year rate guarantees? Are your rates guaranteed for the year? Or might there be a rate change before the year is up?

MR. DOE: Our present administrative practice would be a 12-month rate guarantee.

And that leads into my next question. I gathered that Crown is rerating their cases every six months, is that the practice? When you do that, are you readjusting for age/sex shifts in the data, or are you merely increasing the rates for trend?

MR. ESSERT: Essentially, we give a six-month rate guarantee. For technical reasons, we do not renew them all every six months. The renewals are between six and nine months, and they get onto a particular date, and then they get renewed six months later. The first time around, we did the age/sex adjustment every six months. We found that that has become too expensive. We now do it every 12 months. Even so, if the salesman monitors his particular book of business and sees something going on at that time, or an underwriter who monitors the salesman sees something, we can adjust the rates for age/sex every six months.

MR. DOE: One of the tools that has been used is rerating more often than annually. I was wondering also if we could see a show of hands as to, at least from administrative practice, how many companies represented would be rerating their cases in the 10 to 50 life market or 15 to 50 life market more often than annually?

MR. HAUSER: Again there is a very significant number of hands being raised, for the record.

MR. DOE: In terms of past history, would people comment on whether this trend has occurred more or less in the last two years during financial losses?

MR. HAUSER: I think it was pretty standard practice, up to fairly recently, to have -- as Henry mentioned in his remarks -- a 12-month, and sometimes even longer than 12-month rate guarantee. So, from where I see it, I think it has been fairly new to rerate cases before the first year is up. Anybody else have any comments on that?

MR. CHESNER: Before someone asked about industry categories and I think it is agreed that every rating manual continues to rate using industry categories. Where that is the case, industry has superseded income. I have looked at a couple of dozen manuals in my work, and I would say that less than half the companies now rate by income, and it seems to be that industry is the key and has supplemented income.

MR. KEVIN KENNY: I have a question on Metropolitan's computerized rating system for up to 200 lives for proposals. At what point do you start looking at experience on takeovers? Would not it normally be less than 200 lives, or does it just depend on what is available?

MR. HAUSER: I am not really sure. We might not look at the experience at all on that entire block of business.

MR. KENNY: I was just wondering about other companies.

MR. SADDIK: Over 20 lives, we are starting to look at the experience from scratch for the last two or three years, even if the premium is as low as $2,000 to $3,000 per year. But, we will apply judgment. The higher the premium, the more credible it will be. But, we start looking basically at 20 plus in Canada.