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SMALL GROUP AND MINI-GROUP MARKET

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1. Trends in plan design
2. Underwriting strategies
3. Approaches to marketing compensation
4. Claim cost containment strategies

MR. ALAN FERGUSON: Good morning. I am the moderator of this open forum on Small and Mini-Group. I have the easy role this morning. My job is to introduce the panelists. They are Jerry Stein who is Vice President and Associate Actuary with Prudential. I might say that I was formerly with Prudential and Jerry is one of my former associates. He has been in the small group business for about a year and a half and has had previous experience in a variety of areas: personnel, comptrollers, etc. Another panelist is Irwin Stricker who is Vice President and Group Actuary with Guardian and has spent most of his career in the group insurance business. The final panelist is Dick Sieben who is President of Sieben Associates, a consulting firm in Chicago. He deals mainly in the small group market. He previously was Chief Financial Officer of the Illinois Blues. Our recorder is Ron Dandy who is Associate Actuary with Security Benefit.

This is an open forum. It will, therefore, consist of relatively brief remarks from the participants. We may then have a dialogue between the members of the panel and then we are dependent on you for questions and answers.

MR. JERRY STEIN: At Prudential we have two small group product lines. The first, which we call Employee Benefit Program or EBP, is for 2-9 lives. The second program, Group Security Program or GSP, is for 10-49 lives. These products are primarily sold by individual agents. They are not sold by product trained group representatives. Our product is a product which is managed and controlled by the Actuarial Department rather than by the Group Insurance Department. Nevertheless, it is an area of mutual interest and we talk frequently to our group people. In the EBP product we individually underwrite each life, whereas, on the GSP the case is underwritten, not the individual lives. We have been selling these products for a number of years.

Due to inflation and underwriting problems an assessment spiral became evident around 1981. This followed dramatic sales which were in turn followed by dramatic losses. At the end of 1981 we had about 100,000 EBP cases. We now have about 30,000. At one time we had 19,000 GSP cases. We have about 5,200 now. We think we are bottoming out and we hope sometime this year those in-force numbers will start to rise.

One of the underwriting problems was that thousands of occasional sales were made by thousands of agents who really knew very little about health underwriting. They found a case and they wrote it. The appli-

cant, the employer, was willing to sign the application and it looked like a good case. Too many of those cases were put on the books.

In October of 1982 we stopped selling our old products in these lines. We immediately came out with a new series still called EBP and GSP. We tightened both our individual and our case underwriting standards. Also, we installed a $300 minimum deductible. The employer also has a choice of a $500 or $1,000 deductible and it might be mentioned that there are takers for those higher deductibles.

In March of this year, we made several additional changes in these plans. We introduced a second surgical opinion provision. Under this provision, eligible charges are reduced by 50% where the patient has not obtained a confirming second or third opinion on the need for elective surgery. The company provides the names of physicians which are available for this second or third opinion. In underwriting these cases, particularly the EBP, it must be recognized that the smaller the group, the more the boss thinks like an individual prospect rather than like the head of a company.

One of the other steps that we have taken in the effort to have a good, prosperous book of business is that we have instituted tighter underwriting rules to reduce our exposure to those groups which are unstable, very seasonable, or in other ways probably poor risks. For example, cases with 2-5 employees must enroll all of these employees even if one or more of those employees has other coverage available from some other source, for example, a spouse's group insurance coverage. Cases with 6-9 employees must enroll all but one employee. For the GSP line, at least 75% of the eligible employees must enroll if the plan is contributory. For employer-pay-all plans, 100% of the eligible employees must be enrolled.

With regard to the medical insurance, we also require that the maximum employee contribution be no more than 50% of the employee-only rate. Another underwriting rule that we have (which has eliminated a few cases that look good to our agents but which we think makes a lot of sense from an underwriting standpoint) is that at least two of the employees must maintain separate residences.

One of the topics in our agenda is compensation for marketing small group products. I will give you a quick idea of how we pay our agents. We have a sliding scale of commissions that applies to both the EBP and GSP series. It pays 20% of the first $1,500 of annual premium. The percentage then goes down as the premium goes up. It is 15% of the next $1,500, 10% of the next $2,000 and so on. Where the premium is $30,000 or more, we are paying 3% on any annual premium over $30,000. For example, a case with an annual premium of $10,000 would provide a first year commission of $1,125 or 11.25%.

The service commissions paid in renewal years are also graded but with a few less gradations. We start at 10% of the first $1,500, 8% of the next $1,500, 6% of the next $27,000 and, if the premium is over $30,000, we will pay 3% of the excess. Taking the same example of a $10,000 premium case, the commission will be $690 or 6.9% in the renewal or service years.

In connection with marketing, I think it may be interesting to mention an experiment that we are now conducting in a few selected areas of the country. We have sent into each of these selected areas (there are six of them

right now) somebody whom we are calling a small group representative. This is somebody who, in fact, has been trained to be a big group representative. They have gone through their regular training, and then have spent time with our small group people and have received special product and underwriting training on our products. They are now in the field working with agencies and agents on promoting this business. These small group representatives report directly to us in the Corporate Actuarial Department. They are salaried and all commissions on cases that are sold go to the writing representative. These small group representatives give product training, field underwriting training and sales assistance. On my way out here to Salt Lake City, I spent three days with one of these representatives making sales calls in Missouri and Kansas. It was an interesting experience.

What is on the horizon with respect to claim cost containment strategies? In our company - and I think this is true in most companies selling small and mini-group - small group generally follows big group with innovations. Our second opinions for elective surgery are already in place. Just around the corner, we might be seeing lower deductibles or higher coinsurance for such things as preadmission testing, outpatient surgery and diagnostic testing. We may see higher deductibles and less coinsurance for such events as weekend hospital admissions and hospitalization without some kind of preadmission review. I do not know how far we are from this but I suspect that these are some of the things that will be emerging before too long. We will certainly be seeing more emphasis on less expensive alternatives to hospitalization. Hospices, home health care, post-operative convalescent homes and birthing centers are examples.

As a final remark, I would like to note that with respect to all of these cost containment techniques the insurance company will have to make greater efforts to communicate better with the covered employees than is now done. The small group employer does not have the staff or the facilities and sometimes does not have the inclination to explain and encourage understanding of these features of their medical plan. The burden has to fall on the company and the servicing agent. In many cases, the servicing agent is not going to be as inclined as we would like him to be to give all the details and to follow up and explain these provisions every time a new employee joins one of his client companies. Therefore, it will be very important that the insurance company provides the material that can be easily distributed to the employees and will provide the necessary explanations in convenient, clear and simple form.

MR. FERGUSON: I remember when Prudential removed the $100 deductible and limited deductibles to a minimum of $300. I remember many people in the industry saying: "Congratulations, glad you are first. You have set the way and we will be following." I have not seen that yet. Jerry, on the second opinion, is that for a listed set of conditions or for any non-emergency treatment?

MR. STEIN: The types of surgical procedures which require second opinion are listed in a brochure which we give to the agent to give to the employer to give to the employees.

MR. FERGUSON: About how many do you have?

MR. STEIN: I forget the exact number but my recollection is it is more than a dozen and less than two dozen.

MR. FERGUSON: You mentioned tighter underwriting rules and your insistence on participation standards. Would you like to add anything on how you enforce that? You might also comment on requiring at least 50% contribution by the employer. How do you enforce that?

MR. STEIN: Basically, we have to trust the employer to tell us the truth. The employer sends us the check for the medical coverage and for the life, weekly disability income, and dental coverage if that is included in the plan. The employer collects the employee contributions directly from the employees. We really do not have a formal policing mechanism. In the small town situation, we have had situations where employees have felt that they were not being treated fairly by an employer and talked to the agent. This is much less likely to happen in a larger city situation. To a great extent we are trusting the employer to fulfill the bargain that he made with us to make the required minimum contribution.

One of the underwriting techniques that we have found very successful is phone inspections of the case. This is often done by our underwriters and, less frequently, by a commercial inspection company. These often uncover some interesting information. We have had many situations where we will call and ask details on a particular employee who might perhaps be the spouse of the owner. The telephone operator or the bookkeeper with whom we talk will tell us: "She is never around the office. She just comes around at 4 o'clock to pick up her husband at the end of the day." Thus we find out that we are not dealing with a legitimate employee. I do not want to leave the impression that this is a typical situation but it is the kind of thing that does come up from time to time where a direct telephone inspection has been extremely helpful in identifying problems.

The kind of a case that we do not want was one that I visited with an agent in Kansas on Tuesday. There was a business that looked prosperous. It had five employees: a husband, a wife, a grown son who lived separately from the parents, and two other employees. We spoke to the wife who was in the office and quite obviously was part of the business and was not a problem in that respect. But she had no interest at all in covering the other two employees. It was clear that the intention of this case was to provide family insurance rather than group insurance. The other two people that they did not want to cover may or may not be the healthiest of lives. We have no way of knowing at this point. The chances are, though, that our chance of profit will be enhanced if we get all five. We may be buying some problems if we were to only take the three family members. This is the kind of situation that our underwriting rules are designed to avoid.

MR. FERGUSON: I think that emphasizes the opportunity for antiselection in the small group business and the need to be vigilant in guarding against it.

Jerry, you described the scale of commissions. I believe that when I was with Prudential there was a fee payable to the agent whenever a medical form was completed. Is that still a practice?

MR. STEIN: Yes, on additions to the case where medical underwriting is needed, we pay a fee of $20, I believe, to the agent for his time and trouble in enrolling the life and arranging for the medical form to be filled out. This is a combination of incentive to keep servicing calls up and to make sure we get new blood into the case as people join the firm.

MR. FERGUSON: I would now like to ask Irwin Stricker to make a few remarks.

MR. IRWIN STRICKER: Although, or perhaps I should say because, we specialize in small groups - approximately 95% of our group policies have fewer than 100 lives - we do not market what are usually referred to as package plans. We will permit individually designed plans down to groups with as few as two lives. In reality, this does not lead to an infinite array of plans. Brokerage pieces are needed for the smallest groups and these often contain rates for a particular plan of benefits with simple variations for a few modifications. I believe our willingness to adjust our benefits and schedules to meet varying consumer needs reflects the perspective with which we view small groups. It is the business we are in. We do not see it as an accommodation to a captive agency force or to other lines of business in the company. In regard to this latter point, it is difficult to overemphasize the importance that our senior management support has meant to us. There has never been an instance where an underwriting decision made in the group profit center has been reversed by our senior management. This tangible expression of confidence in our operation has been critical to our success.

With this brief background, I believe the trend in plan design is moving towards less costly plans. The one thing that everyone, or at least almost everyone, can agree on is that medical care costs are too high. How to solve this, unfortunately, is not so clear. Cost sharing and cost containment are responses to employers' financial concerns and the difference between them can get a little fuzzy. To the extent that a higher deductible or a fixed room and board benefit modifies behavior in deciding how to spend medical care dollars, it can have elements of cost containment as well as cost sharing. We, at the Guardian, have the unique situation in regard to the current trend in corporate medical plans. Our bread and butter, from the time we opened up shop in 1957 to this day, has been a major medical plan with no coinsurance. Our marketing thrust has been a plan differential for the upscale market. Buy a Cadillac and not a Chevrolet!

How do we square this with the drift of current events? Frankly, with some difficulty. We do permit the sale of coinsured plans now, something that several years ago required a case by case dispensation. We are writing more and more plans with deductibles greater than the traditional $100. We have introduced a plan with what we call a "dynamic" room and board benefit. That is, for some fixed number of days there is a constant dollar copayment for each day of hospital confinement. Perhaps more important, we have committed resources to an in-depth review of all the cost containment features, and possibly some additional ones, that are currently in vogue. This includes second surgical opinion, weekend admissions, hospital precertification and preferred provider organizations. These, of course, are all concepts that have been used, probably with varying degrees of success, in the larger case market where the drive has been more from the employer than the insurer. With smaller groups, however, we must face up to the problem of employer commitment and insurer communication. We hope to be able to respond effectively sometime next year with a product that will be perceived as both high quality and cost effective. If we succeed, you will probably hear about it.

It is not controversial to say that selection of risk, in any size market, is critical to success. In the larger and more credible size case market, this

requires adjusting the new business premium rates to reflect actual prior experience on a case by case basis. In the smallest cases, and for us that is groups of fewer than 10 lives, we individually underwrite all employees and most dependents. But what of the groups in between the smallest and largest, the groups that, in fact, make up the bulk of the small group market? I believe that field underwriting is especially important here. The ability to weed out potentially significant claims by sensitizing your group sales representatives to ask the right questions has tremendous financial impact on the operation. As an example, I will mention an item such as guaranteed issue limits. A frequently asked question is, "What are they?" Well, we do not have any. There are guidelines that we use for health statements and medicals but there is no life amount we would entertain where we are willing to take a piece of business without asking questions. And, as importantly, our salesmen, or so they tell us, are prepared to turn back a case where the answers are not satisfactory. We are not so naive as to think that in every sales situation every group representative of ours turns over every rock and looks underneath, especially when there is an application and check in hand. But it happens, at least to some extent. It happens because we reward that kind of behavior. We reward it financially, first by making our premium rates rather sensitive to the experience of each geographic area, then further through incentive compensation adjustments which I will shortly describe, and perhaps almost as important, through an awareness that they are succeeding in our corporate environment of writing profitable business.

I would like to comment briefly on the approach that we at Guardian take towards incentive compensation for group salesmen. Incentive compensation at the Guardian is based almost exclusively on the sale of new business. Most of our incentive compensation dollars are generated from the sale of group life insurance. The balance is derived from products that we are currently looking to emphasize. It is interesting that medical care is currently not one of these products. While this is so, it is also true that a competitive medical rate leads to the sale of those products that we do directly compensate for. It is, therefore, well understood that a noncompetitive medical rate, which results from continued poor experience in the region, will lead to reduced sales and lower bonuses.

In regard to the level of incentive compensation, I would like to share some statistics with you. Approximately 65% of our group salesmen's income is derived from bonus. When we break out our relatively tenured salesmen, those with five or more years of experience, we find we had 44 of these representatives in 1983. Of this group, 41 appeared in Schedule G with 10 having earnings in six digits and an overall total average compensation of approximately $80,000. Our incentive compensation, while open ended in that there is no maximum placed on it, is developed on a regional group office basis rather than separately for each salesman. While the method of allocating the bonuses within the group office is currently being reviewed, for the most part it has been proportionate to basic sales salary.

We strongly believe that a well designed incentive compensation formula has been one of the key elements in our success as group marketers and underwriters. We use our incentive compensation formula to set the tone of corporate objectives that, we believe, can be best achieved by a consistency in word and deed. Our incentive compensation is integrated with both our group marketing and group financial plans. This incentive compensation is integrated with our marketing plan by focusing payments on those areas that

currently make up our marketing objectives. Examples are life, disability, and dental insurance. This incentive compensation is integrated with our financial plan by adjusting the bonus based upon the bottom line profit achieved by each regional group office. These adjustments, of course, may be positive or negative.

To sum it all up, we tell our field force that we are interested in emphasizing certain products and that, above all, we want to write profitable business. We expect them to be selective and inquiring field underwriters and we pay accordingly.

MR. FERGUSON: Irwin, you said that you rerate on larger cases to reflect actual experience and you seem to distinguish larger cases from those 10 and under. Do you mean that you rerate based on actual experience for groups of 10 or more?

MR. STRICKER: No, for groups in the 10-100 category, underwriters look at each case. However, the entire decision is based almost entirely on the manual rate. The leeway for experience is maybe one or two points. We tend to set targets for each group office that we expect to achieve to maintain a consistency of manual rates in that area.

MR. FERGUSON: You said that for life insurance and underwriting that you have no inhibitions about asking questions on any size case. But for health insurance, do you not have to have rules which say the break point is 10 lives and below that there is a health questionnaire that has got to be completed?

MR. STRICKER: Yes. For groups of fewer than 10 lives there is an individual health statement that is completed by each employee and, for groups of fewer than six lives, by each dependent as well. Depending on the results of the health statement, we might accept, reject, get an APS, or have a medical. There is individual underwriting for each applicant.

MR. FERGUSON: I would just like to ask you to reaffirm that your bonuses - your incentive compensation - are based only on sales of life, disability and dental. There is no incentive compensation based on financial results although the financial results directly affect rates and indirectly, therefore, affect compensation.

MR. STRICKER: The basic bonus is not based on financial results but there is a factor that is developed which is applied to what otherwise would be the bonus based on the profit or an adjusted profit for the office. This factor can vary by increasing or decreasing the bonus up to 25-30 points.

MR. DICK SIEBEN: I am going to concentrate most of my remarks on what we might call the mini-group end of this market. That can be defined as 1-9 lives or 2-9 or 2-14 and sometimes even up to 2-24 lives. I think it is a very exciting, very difficult and very challenging market. I think that if we briefly survey the kind of carrier participation that we see in the market, we will see a variety of responses to the questions on underwriting and product design strategy that have developed in this marketplace.

We have large carriers who are total manufacturers, manufacturing products for their own distribution forces to the extent that they are doing business in this market through company formed and managed trusts. Companies like the Traveler's, the Lincoln, and the Guardian are in total charge of all of the functions in their participation in this market. Some of them do it through and on behalf of their own distribution forces.

Other large companies which have been highly active have created most of their volume only as the underwriter of independent trusts formed and managed externally. New York Life has done business with a number of trusts such as that in the past. A lot of Pacific Mutual's business came from that direction and other carriers have participated. Where the selling, billing and collection functions are externally managed and sometimes even the claims processing, the company is essentially the underwriter.

We have other large companies who either do not participate at all or participate only to a minor extent. We have companies who have made major movements and withdrawn from all group operations including some major activities in the small group area. In recent years such companies have been Penn Mutual, Integon, Southwestern Life, Capital Life, National Life and Accident and half a dozen more that I cannot think of off the top of my head.

The market is marked with change in terms of carrier entry and carrier withdrawal. We have, very recently, the Equitable decision to stop being a manufacturer of products for the under 100 life market. They have arranged an external product capacity on behalf of their distribution force rather than leave their distribution force with the task of trying to find products. Equitable has other carriers being the manufacturers with the Equitable management selecting and monitoring these carriers for their distribution force. We have another large carrier who has never really participated in the group market, Northwestern Mutual, which looked at and rejected a strategy of becoming a manufacturer and has developed a distribution strategy similar to what the Equitable is now doing.

We also have a number of companies that really specialize in being the manufacturing companies, companies such as State Mutual, Transamerica, and Colonial Penn. I understand Bankers of Iowa, which is actually a manufacturer, has plugged into other companies' distribution forces. They have a distribution and manufacturing strategy but the distribution is not always their own company.

Within these companies, the management of the line may be assigned to the true group operation or it may be assigned to the agency or individual or small business product operations within the company. When it is assigned outside of the group operation, those other operations may buy all of their services from the true group operation, they may develop the skills internally or they may contract externally for the claims processing of some of the sales and billing and collection functions. We have companies that have rather large participation (like the Kemper and the Sentry) who do a lot of these functions internally and sometimes they also contract to have them done externally. Some of these companies may be expanding their participation in this market at any particular time or retrenching temporarily as the Prudential did before going back to an expansionary mode.

Given this uneven level of commitment and enthusiasm in the larger companies, there are a large number of participants who purposely, or sometimes accidentally, specialize in this market with a significant share of their premium generated from small or mini-group business. Companies like Sentry and Kemper and, to a certain extent, the Hartford have attained significant premium levels and remain partial manufacturers. Other companies who are growing with major new commitments include companies that have very large premium shares like John Alden, Celtic Life, Colonial Penn, Mutual Security, and a company called United Chambers Life which you probably never heard of but will handle about $70,000,000 of premium volume at the end of this year.

Then there are companies, such as Iowa State Traveler's and others, who have been brought to their knees by their accidental participation in this market. There have been companies that have been attracted to the cash flow and the premium volume without the management skills to ride the tiger.

With this array of participation, there tends to be a range of prevailing acceptable price, a range of acceptable plan design and a range of field compensation and underwriting strategies. The market does not too richly reward innovation in plan design, underwriting strategy, and cost containment strategies that do not significantly impact the price. Lower compensation is rarely acceptable.

The marketing compensation strategies that appear to pay off in the marketplace are effective uses of the noncommissioned elements of marketing compensation. Within the market there is a tendency, I think, somewhat away from the graded commission schedule and the nonlevel commission schedules that have been mentioned previously. The tendency is towards flat schedules and towards level schedules between first year and renewal. When you deal with the lapse characteristics in the small group market, which will be running any place from 2% to the extreme of perhaps 5% per month, you end up rather quickly coming to a conclusion that 50% of all premium volume is going to be in the first year. Maintaining high first year and lower renewal schedules does not make sense to some of the participants.

The prevailing plan being sold is, of course, comprehensive major medical with life insurance almost always required. Optional coverages include maternity coverage, dental programs, disability income programs, supplemental accident programs, dependent life and a prescription drug card. Within the comprehensive major medical product, the prevailing plan being sold is still a $100 deductible and $500 to $1,000 of out-of-pocket maximum expense with a two or three times limit on both the deductible and the out-of-pocket limit in respect to family coverage. There is some movement to where the lowest deductibles in some carriers' portfolios are $150. The out-of-pocket limit might be moving to $1,000 or to $1,500 but the prevailing plan still accounts for 70% or more of the sales even in the companies that have a portfolio that includes higher deductibles and higher out-of-pocket limits. The only place in the market where the higher deductibles, $500 and up, start to take a larger share is when you move into the over 20 life business where those deductibles are connected with some partial self-funding by the employer. They are not true $500 deductibles to the employee participant.

One cost containment strategy in this market is to simply make a statement that some of the preferred types of treatment are covered. Cost containment is mentioned in every product. A step further would be in terms of some plan designed to offer waiver of deductibles and sometimes waiver of coinsurance for these preferred treatments.

What is happening more recently is a movement towards disincentives for the types of treatment that you are trying to avoid. The most frequent of these is the development of split deductible or double deductible plans where the normal calendar year deductible of $100 may have an additional $200 deductible per hospital confinement. Some additional nuances start putting daily deductibles on hospital confinement.

When you look at the impact that these kinds of features have to have on price in order to make a dent and be acceptable in terms of the marketing, you deal with an annual in-hospital utilization rate of a small group pool which is usually characterized by being much younger than the average population. You may be talking about hospital incidence rates of 6% per year. For a $100 deductible, you are talking $6 a year, 50¢ a month against an average monthly premium of $100. It does not make a tremendous dent in terms of price.

In a market where price deviation may range up to 100%, the task is to determine the price and product that will sell and to set the underwriting strategies that will be profitable and successful for your company. What are the characteristics that will dictate the underwriting strategies that you have to develop? First, you have to be highly aware of the high lapse characteristics of this market. No matter what happens, over a period of time, 50% of all business written will have left you. It may take you a year in one instance, it may take you two years, it might take you 30 months but only 50% of the initial business will have prevailed. Because of the great price variation in the market, it certainly has an impact. There is a tendency for the groups who have high claims not to go out and go through the preexisting condition requirements again or whatever is necessary to re-enter the market. As a byproduct, the more select and the better and the healthier risks will leave and you will end up with a disproportionate share of the higher risks that are prevailing. No matter what the technique of underwriting is, there is some select and ultimate experience that comes home relatively quickly in these types of pools.

The prevailing rating strategy that is involved in the smaller groups are what I would call rate specific or the offering of a rate table. If an employee who was 40 years old leaves, that rate is dropped and if a new employee comes in with different characteristics, then a new rate is added. In other words, a group average rate is not guaranteed, the rate table is guaranteed.

In order to get a differentiation in price, the first year rate guarantee to a new piece of business may be for 12 months and the renewal rates may be set for 12 months. On the other hand, the initial rate may be guaranteed for six months or even for three months. Rather than go through 20% annual price increases, some participants have found that 5% quarterly price increases are more acceptable and have less impact on persistency. The deviation between first year and renewal price guarantees may be different. It may be 12 months in the first year and then more frequently in renewal periods.

The rate table itself: how often and how frequently is that maintained? There are still some companies who make changes in their new business rate tables only as frequently as annually. There are some carriers who index them monthly. The prevailing norm, I would think, is probably about six months with some carriers changing their rate cards to their field force as frequently as quarterly.

A lot of the decisions that are made in respect to the type of underwriting and the type of selection are dependent upon the carrier's source of distribution. Companies who are working with their own distribution forces cannot be as tough and punitive toward agents who have perhaps done something which is less than honest with respect to an application. They cannot move as easily and rapidly to rescind coverage and take the other steps that may be considered appropriate when actual misrepresentation is found on the application.

Obviously, with the select and ultimate experience characteristics that we are talking about as a part of lapse, when we introduce the strong medical underwriting that many of the participants are doing in this marketplace, we add an additional select period of time to the combination of that in preexisting conditions. As a byproduct, this leads to some carriers' decision to maintain a differential between new business rates and renewal rates. Many carriers maintain the same prices for existing cases that are, say, two years old as they are offering to new business. Other carriers, in respect to the type of allocation of first year expense versus renewal expense that they actually incur in this market, find cause for having a lower price for renewing cases than for new business. At the other end of the spectrum, when carriers are going through medical selection and they find that there is a 20-25-30% differentiation in the claim cost experience between first year and renewal business, then we find higher renewal prices from first year prices.

We have carriers who can take the prevailing rate in the marketplace and secure significant first year profit. At that prevailing rate there are carriers who are losing money through their underwriting strategies and there are carriers who are making significant first year profits. Some of the companies with the lowest prices have the highest profit margins. Some of the companies with the highest prices have the highest loss ratios. All of these are impacted in the decisions that a carrier makes.

With as wide a degree of variation in the marketplace, strategy is extremely important. If a carrier is successful in the marketplace, it has the capacity of adding $30, $40, $50 million of premium in a rather rapid and short period of time. Then the actuary and the pool managers have the very difficult task of trying to interpret what it means in order to make the decisions that will impact the increasing volume the following year.

MR. FERGUSON: Dick, you referred to Iowa State Traveler's as being "accidentally involved" in the market. Do you want to explain what you mean by that?

MR. SIEBEN: There are a lot of pieces of trust business out there that have been for a long time externally managed. Sometimes their carrier, for reasons of changes of heart, changes of management, perhaps getting burned, decides to leave them. Those pools are shopped to someone else.

I think that people do not know what they have gotten into. I would call it accidental when you commit a company with a couple of million dollars worth of surplus to what turns out to be $30 million of premium risk where a 5% error could be fatal.

MR. FERGUSON: You mean that you may be dealing with an overenthusiastic TPA.

MR. SIEBEN: Yes, and sometimes there is overenthusiastic management. I am aware of one situation where a carrier, who had never been in the business, was so impressed by the premiums that he took the early cash flow and put it in long-term bonds. Then when time came around for him to pay the claims, the market was down and service suffered. The license to own an insurance company is not as strict as the license to sell insurance.

MR. FERGUSON: You referred to per person rates and maybe some of the panelists would like to comment on that. In the Prudential, for example, there are per person rates, depending on the age and sex which are adjusted for ins and outs doing the year up to 10 lives. Over 10 lives it is a group rate, established once a year, and then reevaluated with the 12 month census.

MR. STEIN: Yes. Once a year, based on the census, we establish an employee rate and a dependent rate and that applies to any new entries or drop-offs during the year.

MR. SIEBEN: There are carriers who are extending the rate table that is used under 10 lives up to as high as 24 lives.

MR. FERGUSON: I think some carriers now are recognizing the exact age of spouse where previously that was not usually recognized.

MR. STRICKER: We individually rate groups of fewer than 10 lives but it is only on age. We do not take sex into account.

MR. FERGUSON: Do you want to comment, Jerry or Irwin, on how frequently you change rates and what sort of guarantees you give?

MR. STEIN: We guarantee that we will not change the rate more frequently than every six months for an existing case in the series that we began selling in October of 1982. I believe we only change rates once a year because of the contractual provisions in the pre-1982 business. However, we examine our experience and our trends quarterly and there are quarterly rate changes. A particular case on our current series, therefore, gets involved in every other rate change. The actual rate increase that they will experience on their semiannual rate increase dates will reflect the compound effect of two quarterly reevaluations.

MR. STRICKER: The only published material that we put out where we guarantee rates is our proposals on new business. We guarantee them for one year. On existing business we have the contractual right to change rates on any premium due date. Actually, we have never, to this date, increased rates more frequently than once in any twelve month period. We are sticking with the 12-month period for existing business although,

if things fell apart, we would have the right to have an off anniversary increase. For our new business rate changes we do send out material, brokerage pieces and rates to brokers. We make a review of our rates quarterly. Currently we are changing them every six months. About a year or so ago we had a brief period of time where we were changing them quarterly.

MR. FERGUSON: Dick, you referred to lapse rates on the order of 2-5% per month. Were you speaking of cases and not attrition within cases?

MR. SIEBEN: Cases.

MR. FERGUSON: Jerry or Irwin, would you like to comment on what you see in lapse rates?

MR. STRICKER: Our experience has tended to be a little more favorable than that. Two percent is about the upper end of the lapse rates that we have experienced. A couple of years ago we had lapse rates of approximately 24-25% a year. Our current lapse rates on groups of fewer than 10 lives are running about 18%. We have had periods of time where they were as low as 10-12%.

MR. SIEBEN: I think that tends to vary with the relationship to the distribution force. With agency loyalty and your own agency plant, 2% or perhaps better will be experienced. When dealing through brokerage and distribution that has no ongoing relationship with the company, you are in to the 3-4% range. 5% is more of an extreme.

MR. FERGUSON: I think, Irwin, you are dealing primarily with brokers, aren't you?

MR. STRICKER: About 80% or probably maybe a little more of our business is sold through brokers. Our company full-time agents are perceived by us as a separate marketing and distribution system and we actually treat them as we would treat brokers. I think perhaps one of the reasons that our lapse rates may be more favorable than those of some others is that not everybody sells a no coinsured plan down to groups with two lives. This plan is difficult to replace.

MR. FERGUSON: I would think though it would be expensive. Jerry, do you want to say anything on lapse rates?

MR. STEIN: First of all, our marketing is primarily done by our own agents. We do get some brokerage business but it is probably in the magnitude of 10-20% of our sales. Our lapse experience on the business under the new series has been running in the low end of the range that Dick was talking about.

MR. SIEBEN: The administrative part of the lapse risk has been passed off many times when dealing through outside administrators. The typical contracts for all functions of sales, claims payment and the processing may go from 20-27% flat first year and renewal. From the carrier perspective, it is the underwriting characteristics that impact it rather than the loss on lapse. Administration, what it costs to put a piece of business in force, is somebody else's responsibility.

MR. WILLIAM SONNLEITNER: This is a question directed to Jerry Stein. When you get into the 2-9 life cases where you do individual underwriting you also have preexisting conditions on those cases, right?

MR. STEIN: Yes.

MR. SONNLEITNER: You are getting pretty close to the individual market. You had an example of a five life case where you found that two of them maybe really would not be on the case. You would not take just the three people as you wanted all five. I am wondering with the underwriting that you do and the preexisting why there would be such a big problem taking three out of the five lives?

MR. STEIN: We found through a lot of analysis of problem cases, especially in the smaller sized area, that the quality of the lives that were covered was generally substandard where there was significant number of lives excluded. The kind of case that I gave in an anecdote before is far from atypical. It is quite normal to come up with a case in which a large percentage of the people they want to cover are relatives - might be a brother-in-law, nephew, husband, wife, or child - where there are all kinds of reasons given why the other people cannot or should not be covered. We have found that this is generally substandard business. Our agents tell us that at times we are turning away good business and I am sure that is true. We feel, on the average though, we are protecting our book of business by following these underwriting rules. We may be, at times, turning away a good case but we think that in most cases our premium will not cover the hidden risks. We are not getting the other lives who very likely are good lives where the premium will exceed the claims that will emerge on those lives.

MR. SIEBEN: I can give you a different opinion on a six life group where there are carriers who will not count as eligible employees those employees who waive coverage for valid reasons (such as having coverage elsewhere). To the extent that there are individually rejected lives, of course, those employees are not required to participate. They may waive coverage for two, deny coverage for a third and write the remaining employees.

MR. STEIN: In considering participation requirements, we allow for the persons whom we reject. For example, in a five life case where one is rejected, we will take the other four lives.

MR. FERGUSON: What do you do in a situation that Dick described where one or more of the lives says: "I do not need coverage, I am covered elsewhere."? Will they be included in the eligible group?

MR. STEIN: They are included in the eligible group. At present, if we do not meet the 100% on a five or less life case or all but one on a six to nine life case, we will not take the case.

MR. SONNLEITNER: Then you feel that the antiselection overcomes your medical underwriting and your preexisting conditions?

MR. STEIN: Yes.

MR. FERGUSON: I would add to that that I think the lives involved - no matter what evidence you get (health statements or APS or whatever) - know more about their health than you do.

MR. WILLIAM KEFFER: I am impressed with the potential value of what has been called field underwriting and also with the difficulty of monitoring such things as participation requirements and contribution requirements. I wonder if Dick or one of the other panelists could expand on what they might have observed among other companies as to approaches in this regard. Irwin's comments pointed at compensation as a factor and then a close relationship on profit monitoring. Are there other effective ways that you have observed that have operated in this area?

MR. SIEBEN: I think we have gone a long way from the point where we relied on participation and employer contributions and extended some kind of an extrapolation of group rules down to this market. To the extent that those carriers that relied heavily on medical underwriting, there tends to be some watering down. In other words, they cannot rely on the participation being there and they cannot monitor it long term. They feel that when you are talking about an average premium for a family at age 40 that is well over $200 a month, you cannot rely on the employer to really pay half of it. They are protecting themselves with their underwriting. They do not look too seriously at those rules because those in themselves are not enough to protect them. I have found that attitude. Rather than worrying about monitoring, protect yourself in terms of who you underwrite.

MR. FERGUSON: I think perhaps what Bill was getting at was what kind of sanctions or incentives there may be for the field to do a good job in selecting cases. For example, Irwin, you mentioned what you do at Guardian. I understand that John Alden has a strict program where they use more professional small group agents whose compensation depends heavily on the quality of the business. As a result, they generally get very good quality business.

MR. SIEBEN: In one sense, in the extreme, if an agent has burned a company, that carrier will not take any more business from that agent ever. Sometimes in respect to where they have been burned and there has been some kind of punishable action on behalf of the agent, they have gone after that agent, not only to correct the particular situation but also to act as a deterrent to others. That is not positive monitoring, it is the negative monitoring in terms of where they feel they have been had.

MR. FERGUSON: I think there is very definitely a "sentinel" effect involved. If you can show by example what you have done in the case of a bad apple, the word gets around. Jerry or Irwin, do you want to add anything else to that?

MR. STEIN: Since most of our business is written by our own agents, we have an agent's responsibility program which is not as tough as our claim people would like and a lot pickier than our agency people would like. We think it is fairly successful in highlighting the situations that cause us to put bad business on the books. We believe there is a sentinel effect. It is nothing that will fully satisfy all parties involved but in general it keeps most agents aware of their responsibilities.

One other thing I should mention is that in our small group representative program where agents are being given a much more intense exposure to this product than they have for several years, we have emphasized, as part of that program, that this can be a good income producing product for the agents but only if they do good field underwriting. If they put bad business on the books, they will make a few dollars for a few months but they find that they may not have a product that is salable from then on. We are trying with education and persuasion to make the agents feel that they are partners in this field underwriting job.

MR. FERGUSON: I know of one TPA that has systems capability to produce on a screen the total experience of an agent. If there is any question, they can focus in on what quality of business and what results they have had from that agent.

MR. STRICKER: As I mentioned, our main thrust is to sensitize our group field people to, in effect, establish long range relationships with the brokerage community so as to qualify the kind of business that they are willing to accept. Part of what we encourage our field people to do in establishing that relationship with brokers is, in effect, to help them place business that is not acceptable to us.

MR. KERRY KRANTZ: You were already starting to answer my question in the last couple of minutes, but to ask it anyway, I am wondering what objective and subjective standards are used in underwriting the broker or the agent? It is obvious that you can look at the experience of the groups that he writes: his loss ratios and his lapse rates. You can also look at whether the person is combative when it comes to trying to get his way and trying to get something for himself or for the group as opposed to trying to cooperate with the company. I would like to hear the panel's views on the subject.

MR. FERGUSON: Maybe, I could just extend your question. One of the things that we have been discussing among ourselves is the mission or objective of the company: whether this business is written with the objective of making a profit, breaking even, or as an accommodation that can subsequently lead to ancillary products. I think this has some connection with your question.

MR. STRICKER: An inquiring group representative can develop his own method of understanding the kind of business that he is receiving from brokers. There are questions to ask and times that people do not ask questions. We tend to rely on our group representatives and the relations which they have developed with producers as our method of field underwriting.

MR. SIEBEN: I think that some of it depends or goes back to the question on when you know that a mistake has been made. There can be some awfully tight contracts with very tight preexisting conditions and some very tough medical questions. The next question is whether issue is really based on a tight look at that. But then what happens afterwards? The claim monitoring and the processing to determine it can be very, very weak in terms of exercising your contractual rights. Once the discovery is made that there was some misrepresentation in which the agent or the individual participated, what action is the company willing to take in terms of payment, rescinding of contracts, actually denying claim,

and going to court. In one instance I know of, a company (this is more on the individual side but the characteristics are much the same) who, on all the questions on the medical application, gets the agent to initial those responses at the top. If they are sued, they will join the agent in a suit to stop the defense that the agent filled it out and told the applicant that it was all right. They will go after the agent in terms of his Errors and Omissions coverage. It is what you do with the claim information and how you characterize agency participation to the extent that you really discover that some misrepresentation happened at the front end. This is one technique. Again, I am talking about the negative monitoring. There is also positive monitoring.

MR. STEIN: One of the most difficult problems we have with regard to monitoring field underwriting is that we have very little in the way of statistically valid information since most of our cases are occasional sales by the agents. The typical situation is that in an agency of perhaps 30 or 40 agents, only a few of them have each sold one or two cases. At that rate of sale, the experience on the individual case may not really be indicative. It is not statistically indicative of the quality of any one agent's field underwriting and even the experience of those half dozen cases that came out of that agency is probably not indicative of the quality of the field underwriting. Of course, as the numbers build up, there may be some valid conclusions that can be drawn. We do have systems that are producing all the kinds of numbers that tell us what is happening from an agent's, agency, and regional perspective. We hope to reach a point in the not too distant future where at some level the data will be significant enough to draw certain conclusions about the quality. Particularly we would like to be able to identify the quality on an agency level because then we have somebody that we can pin responsibility on. That is both positive rewards if results are good and negative rewards, punishments of some sort, if results are bad. In all probability, for the foreseeable future, a significant amount of our business will still be the occasional sale for the occasional agent. We do think that we will be reaching a point where the majority of our business is coming from enough areas that sell enough business that we will have some statistically valid basis of judging the attitudes and habits of that area and that agency. At that point, we will be seeking ways of rewards and punishments: financial rewards and punishments to encourage better experience. We think that management has a very strong role to play in the kind of business that the agents and that agency bring in.

MR. SIEBEN: I would add that I think the monitoring in respect to an agent's block of business has to be highly tilted towards observing the first year experience. As things wear off, I do not think you can totally hold the agent responsible for the chance deterioration that happens two or three years down the line. It is his first year experience that counts.

MR. KRANTZ: The kind of objective standard that I was seeking was the example where you have a broker who asks if a case can be backdated to the first of the month knowing full well that the owner of the small business or one of his children was in an auto accident or something like that between the first of the month and the day that the case is placed. I think that might be considered antiselection.

MR. STEIN: That is a very polite way of putting it.

MR. JOSEPH MORAN: Question for Jerry Stein: Now that Prudential is active in the Health Maintenance Organization (HMO) business, how does the existence of a Prudential operated HMO in any area affect the products of group insurance available to the small employer under 50 lives? Do you have provision for selecting HMO enrollment as an alternative to the insured health coverage?

MR. STEIN: Joe, we have not had many situations yet where the two types of products have clashed. We do not have the kind of participation problem with the larger cases within our GSP band that would cause us to reject a business because of the number of people opting for HMOs. We have not run into situations where very small employers (under ten employees) wanted to participate in the HMOs and therefore created a conflict with ours or a non-Prudential HMO. To a great extent we are dealing with employers who are seeking simplicity, seeking a solution to a business problem or possibly a solution to a personal problem, but are not interested in such things as dual choice and all the other paraphernalia with HMOs plus insurance coverage. Whether the HMO is a Prudential HMO or any other HMO would not influence our own handling. We would be at arms length with Prucare facilities if we ran across them just as we would with a Kaiser or any independent.

MR. MORAN: I was posing the question from a little bit different perspective. You are not offering access to a Prudential HMO as an element in your marketing to groups of 25-49 lives. In other words, do your small group customers have the HMO option routinely available, is it a special feature that can be made available, or is it just disregarded completely for groups in those areas where you have a Prudential operated HMO?

MR. STEIN: Again, Joe, the question from our standpoint is whether there is an HMO in the area and whether there is a desire on the part of the employer to participate or, if it is a large enough group, whether they are petitioned by the HMO to be offered. Our action would not differ whether it was a Prucare or non-Prudential HMO.

MR. FERGUSON: I will be presumptuous and chip in as an ex-Prudentialite. There is no compensation to the agent involved if there is HMO coverage provided, so it is really not part of the package. I think the only other problem that Prudential ever had with HMO coverage is where there were groups of say 25 lives or more where offering the HMO option was obligatory and they sign up with an HMO but they also want dental coverage which is not offered by the HMO. I do not know what the situation is now, but Prudential did not offer dental coverage without major medical except in some situations in California where this dual choice was prevalent.

MR. MORAN: Can I then generalize on the same question directed to Dick Sieben? Is he aware of any marketing efforts in the small group area by other companies where part of the package being marketed is access to HMO alternatives?

MR. SIEBEN: No, I am not. I do not know what the bottom of it is, but so many HMOs are not offering to put in coverage in groups of under 25 lives. The access to HMO coverage is quite restricted for the smaller employers.

MR. ROBERT SACKEL: One phenomenon that I found, especially in the recent recession, is that a number of 10+ life groups have reduced to 1-9 life groups with different underwriting rules and different rates. How do you handle this?

MR. STRICKER: This has always been something that occurs. A group of ten or more lives will drop to a group of fewer than ten. I am not sure exactly what the time period is that we allow a group to be below ten lives, but after some period of time, if it drops below nine or eight, we impose the rules that we have on our groups of fewer than ten. Also, we would have the option to terminate the group.

MR. SACKEL: Are you saying that you require evidence on new people?

MR. STRICKER: We require evidence on new entrants, right.

MR. STEIN: The situation at Prudential is about the same.

MR. SIEBEN: I think a much more common problem is when, in the 2-9 or 2-14 life pools, the groups drop to one life. Many carriers feel that they ought to exercise their requirements and cancel that case, other carriers take the opposite point of view and some of them just do not get around to it.

MR. CHARLES SHERFEY: There is an underwriting feature that goes by various names, most frequently called no loss, no gain, that is required in some states and offered voluntarily by some companies. I was wondering what effect that has on experience and, if it is adverse, what approaches are available to offset it?

MR. STRICKER: We have always offered no loss, no gain to groups down to two lives from the time that we started writing it. Basically, it is just part of our experience.

MR. FERGUSON: You do that everywhere, regardless?

MR. STRICKER: We do that everywhere regardless of statute.

MR. STEIN: Same with Prudential.

MR. FERGUSON: I think it can go 180° the other way in that carriers would say "Our trust is not in a no loss, no gain state and therefore we do not have no loss, no gain anywhere."

MR. ROBERT BARTHOLOMEW: I am just kind of barely aware of the concept of self-insurance, but I am wondering if you would comment on the comparison in trends for self-insurance in the large medical group vs. the small medical group?

MR. STEIN: There is no involvement that we have nor am I aware of involvement in formalized administrative services to small groups that want to self-insure. What is not at all uncommon in the very large deductible plans is that there is informal self-insurance by the employers for the amounts up to the deductible. The insurance premium is, of course, much lower because of the very high deductible and they are taking the chance that they will be able to financially manage the claims of their

employees below that deductible level. I have heard remarks such as each of the partners in the company kicks in $70 a week into the pot for employees and that is their self-insurance pot. We, of course, have no responsibility or involvement in that pot and we work on the assumption that the employee is responsible for his medical expenses until our deductibles are reached. However, I think that is a form of self-insurance that some employers, particularly employers with a stable work force, do employ which might be considered self-insurance.

MR. SIEBEN: I would agree that there is a lot of that going on particularly in the 25-50 life market. It has been done sometimes covertly and sometimes overtly. When you have the cash flow squeeze that induces so many larger employers to go to self-insurance, not so much for the self-insurance but in order to essentially reclaim the reserves and go on a pay-as-you-go basis, the opportunity for formal self-insurance arrangements in the small end of the market was not there. But a lot of people realized the opportunity of a 25% immediate savings in this month's premium by going to $500 or $1,000 deductible plan with an indefinite "what is it going to cost me to make my employees whole on the remainder"? A couple of carriers actively solicited this and offered to pay the self-funded portion. I believe that was part of the strategy of Wisconsin Employers Group and they did it in a fashion where they, as I understand it, were paying the same dollar commissions on the $500 plan that they were on the $100 deductible plan. They presented the opportunity: "The insurance premium is less. This is on a pay-as-you-go and we do not know what it is going to be." People who did not have the money bought this opportunity.

MR. STRICKER: We are getting some field pressure to go down to groups as few as 50 lives with plans that have something like a $10,000 deductible and aggregate Stop Loss. I have been fairly negative about this for groups in that size case market. The approach that we are taking now is to develop a reinsurance facility to handle the risks. My feeling is that when there are a lot of sales in groups of that size for those kinds of plans then essentially something is priced wrong.

MR. MORAN: As a follow up on that question, at one time, a few years ago, there was a pretty substantial volume of business under totally noninsured multiple employer trust plans. I wondered if the panelists have any estimates as to what the volume of business is today that is handled by the administrators without benefit of an insured company behind them?

MR. SIEBEN: I am just trying to think of the headlines I have read. The frequency of headlines has gone away. I think that it has diminished rather substantially.

MR. FERGUSON: I would say it was more prevalent perhaps in California and I think that what they have been doing there has put a stop to it.

MR. SIEBEN: There are other parts of the country too, but it has dried up.

MR. KEFFER: The Rand study developed a considerable degree of evidence about the effectiveness of coinsurance. I have encountered a body of opinion among group actuaries that the existence or nonexistence of an employer plan filling this gap on deductibles should be reflected rather

directly in judging the expected costs on the insured portion of a $500 deductible plan or what have you. I wonder what the panel's reaction would be to that. Do you consider that significant? Do you try to pay attention to what an employer might be doing with coverage of a noninsured, informal nature below the level of the actual insured plan that you are underwriting?

MR. STEIN: Well, frankly Bill, we rarely would know about these plans. The kind of situation that I mentioned before, where I heard about the three partners that were kicking in $70 a week, was sort of an agency conference, scuttlebutt-type of story well after the fact. It never becomes part of the underwriting information that we have available at the time we are looking at a case.

MR. SIEBEN: A couple of the carriers who have actively marketed such programs, including the fact that they will administer that employer-paid part of the deductible and get reimbursed by the employer, price the product to that. Then from the marketing perspective, when they do not have that arrangement or when they cannot prove and do not know that the employer is self-funding, there is a lot of pressure for a discount. The punitive side of it is trying to come up with a 5 or 6% load the other direction. Some of them formally do that but I do not think they ever really know.

MR. STICKER: We found that very difficult to monitor. We were active ten or so years ago in selling a $1,000 or $2,000 plan. We initially thought we were selling this without any underlying plans of reinsurance on the part of the employer. We found that it was impossible to monitor.

MR. FERGUSON: You mentioned, Irwin, reinsurance in some of these cases. I know of some arrangements where there is a $1,000 deductible, so that the employer with an exposure of 10 lives has a total exposure of $10,000, which may then be limited through some reinsurance arrangement. I think the carriers that have offered this type of reinsurance have found it very, very difficult to price.

MR. DAVID KRUEGER: Dick, we too have run into different companies who two or three years ago didn't have too much in small group premium and now have $50 or $100 million of premium. I am wondering where you would think this is coming from? Is it from the individual market, from Blue Cross or from where?

MR. SIEBEN: I think this market has a tremendous capacity to find a weak link. I think that is the danger in it. If you come up with a sound program and underrate the state of Michigan by 20% for some kind of agency consideration, then you are going to be successful in Michigan. If it is growing so fast that the underwriting is lagging and everything is getting issued, then the market finds its way to that product.

MR. FERGUSON: So perhaps one rule in this market is that if your sales suddenly go up by 50% there may be something wrong.

MR. SIEBEN: That can be. It is amazing if you look at the health insurance statistics on a company basis in terms of the change from year to year. You get that five year statistical base that Insurance Data, Inc.

publishes. They ran a separate tape on group volume and seeing the companies that went from $20 million to $50 million or from $40 million to zero in the course of a year or two is just incredible.

MR. TIMOTHY LEE: I would like the panel to go into a little more on renewal rating procedures, particularly for the under 15 life groups. Do you lump all groups together for one pooled rate or do you try to give some credibility to experience by perhaps doing some kind of tiered renewal rating? Do you have any systematic procedures for cancellation of groups?

MR. STRICKER: We pool all the experience. We essentially tend to aggregate it by regional office and then the renewal rating is made a function of the manual rates. We do not use tier rates. Our renewal rates are approximately the same as our new business rates. If anything they might be 1% or so less than that. There have been situations a little higher but not usually. We have not been doing the tier rating which, I guess, some other companies have been doing.

MR. FERGUSON: You did say, Irwin, that the underwriters will look at the case and maybe vary it a point or two.

MR. STRICKER: I think the under 15 life groups are looked at as those that are medically underwritten. Underwriters do not look at groups that are medically underwritten. These are entirely pooled.

MR. SIEBEN: Many carriers behave as you do where the first year and renewal rates are essentially the same. Pools that are growing rapidly, where the mix of business is mainly first year, may not get around to having a problem and to having to make any differentiation for a period of time. In the situation where a pool has gotten out of hand in some way (for example, the errors we all made in 1980-1982 in anticipating the jump in health care prices) a number of carriers have found that in order to have viable new business rates some differentiation must be made in the renewal rates. Tiering has been a popular response to that. It might be to the extreme of 85% of the business is going to stay pretty close to new business rates and that other 15% might have four or five bands of 10-15% which have got some sort of tilt towards credibility with a couple of years of experience. The theory is you cannot tell the good ones but maybe you can stop the bad ones.

I have seen things as extreme as differentiating on renewal rates by a factor of as much as 300% on very thin experience. This is not much more than a conscious strategy to drive out specific pieces of business on the theory that somebody will always take it, regardless of different responses from insurance departments as to the integrity of doing that or anything else. A different strategy totally is the recognition of select and ultimate costs. If you are not going to charge ultimate rates on day one then give some price benefit out of that extra 15 or 20 or 25 points that might be available with tight medical selection (which will wear off). If the new business rates are perhaps 10% less to reflect that, then there is the problem in renewal periods of reflecting not only inflation but the deterioration and loss of the selection as well. In those instances, a very conscious higher pricing on renewal business will happen two years out, three years out from what current business is being sold for.

MR. FERGUSON: And the customer is made aware of that at the outset?

MR. SIEBEN: Sometimes they are, sometimes they are not. Sometimes the offer of a different product, with a higher deductible to try and alleviate those rate increases, creates product rate differentiation. If that product is the only one available to new business, all of the business on the old product series no longer has new business involved. Pricing differentiation does happen that way. It happens that way a lot more than maybe formally stated within a particular product pool and its duration.

MR. FERGUSON: Would you add anything, Dick, on the situation where there are select and ultimate rates. Can the case come back in as a select case? Can you have a reentry group?

MR. SIEBEN: If you create the situation where in your renewal rating, say 24-30 months out, you are starting to have to add 10% per year to annual trends, of, say, 20%, you are going up more than the prevailing market and you are going to impact lapses. You are starting into some form of an assessment spiral. Do you just let the better business that can be replaced elsewhere elude you or do you actively go out and make an offer, a new business offer, to reenter one of your new business pools? This means going through all of the medical underwriting, etc. In other words, offer the qualifying case at the best rate that you have available. To the extent that you do that, you exacerbate the effect of the assessment hit but you shorten the period of time over when it happens: maybe you move a year forward in terms of the lapse characteristics. If you are going to differentiate and charge higher than new business rates for your renewing business, are you or is somebody else going to write the business that would requalify? If you go out there and actively solicit that, you create another problem on the back end. There are carriers that feel that active reentry solicitation is good business rather than losing the opportunity to write that account.

MR. KRANTZ: I heard the word state regulation and that inspired a question for me. We are planning to file a trust in Florida or to extend to Florida our trust. I became aware of a proposed regulation that they have that has not been acted upon as of yet. When I looked it over it looked mostly like an individual accident and health type regulation where, if you are going to change your rates, you have to justify them based on loss ratios on a historic basis and on what your future experience is supposed to be. When looking at it more carefully, though, it said that group insurance was also covered by the regulation. I am wondering if anyone is familiar with any types of rate regulations that are being proposed among the state departments of insurance as far as justifying our rates as reasonable with relationship to the benefits offered and actually presenting experience to justify our rates.

MR. SIEBEN: I have not seen the regulation, but I am aware of an instance where the Florida Department treated a trust as discretionary group and asked for a rate justification. I do not think they have the law and the regulation to do it. It is a very puzzling phenomenon.

MR. STRICKER: We file rates with a number of states. I am not sure if Florida is one that we are filing with now, but I do not think that we have had any problem with justifying our rates on groups of fewer than 10 lives, on a bulk basis, where we have filed with departments.

MR. STEIN: We have not had any problems of that type.

MR. PARMESHVAR SHARMA: I filed some rates in Florida and did not have any problems except that they wanted a level rate throughout the state. I had to testify on the difference between one location and others.

MR. KEFFER: We, as you may have heard, had some difficulty with our small group business a few years ago. We did engage in a tiering type process with respect to renewals. We had an inquiry arising from a complaint from New York with respect to rate differentiation and, so far as I know, a reasonable explanation that on an actuarial basis supported the classification of risks in these pools was acceptable to New York.

MR. FERGUSON: That is a very interesting comment, Bill. I think some of the differentiation in tiers and rerating levels probably cannot be actuarially justified. The statistics you develop on a 6, 9, or 12 life case just do not support the validity of saying this is a good or bad case. Psychologically, however, I think it is much easier for an employer to accept a 40% rate increase if he knows that experience is poor and psychologically it is very difficult for him to accept a 30% rate increase if he knows he has not had any claims. I think that from the marketing point of view, there is a lot to be said for tiering, although perhaps it is difficult to justify from the strictly actuarial point of view.

MR. SIEBEN: I think that the primary techniques in tiering, of course, are based on some kind of assignment to a rating pool by loss experience. There are other methods that are applied: for example, the offer to an existing pool of a different product on a qualified basis. This, in effect, leaves those that did not qualify on the basis of their own experience subject to a higher rate. Some look at the actual geographical experience. Any other use of a characteristic, that may put some high cost and perhaps a few low cost cases in the same category, that is systematic, independent and not arbitrary on a case by case basis has been acceptable to the departments.

MR. FERGUSON: I think that some of these attempts to reflect experience have been some limit on the charging of large amount claims and even a look to see if the individuals that caused the claims are still with the case or not. Was yours, Bill, based on pure loss ratio evaluation?

MR. KEFFER: No, it was a classification that we felt could be supported in terms of not just experience. Of course, experience itself on a small case was not of any significance.

MR. FERGUSON: What other factors were involved?

MR. KEFFER: Size, benefit patterns, and we did make a change in our deductible program. I think in this particular case the employer was concerned about a change in benefit and the application of our rules for the acceptable benefit levels was questioned. There was a situation with a very high claim on the case and the explanation of that was part of it.

MR. MORAN: Alan, I am not so sure that you should be so quick to dismiss the potential credibility of bad experience as an indicator of future experience.

MR. FERGUSON: In fact, I am not. I am all in favor of it.

MR. MORAN: I believe that if you take the experience for two successive years and subdivide the second year experience into the data for the groups that had low, average, and high claim levels during the first year, you will find a substantial degree of correlation even when you are dealing with groups of this size. An analysis of this type should be useful to support any tiering approach to renewal rerating systems. The problem, of course, is that it has to be a dynamic arrangement under which a group that gets tagged as substandard one year is subject to reclassification back into the average category at a subsequent date.

MR. SIEBEN: I think you are exactly correct in that the category of business that has had the excessive loss ratio is most likely to repeat. The problem is to talk people out of believing that good experience is not subject to fluctuation the following year. Otherwise, they attempt to underrate all those cases with less than 60% lost ratio last year which could result in rating themselves all the way out to 300% next year.

MR. FERGUSON: Jerry, do you have anything to add to that? I know that the study that was done at Prudential tends to somewhat contradict what Joe said.

MR. STEIN: We develop statistics and have the capabilities through the magic of the computer for developing statistics on an infinite number of bases, like the number of letters in the agent's last name. We really only picked two as being significant enough to affect our rating. Those are the geographical area and the industry code. While we adjust the base rates more frequently, we also adjust these two parameters once a year. We do some fairly extensive analysis. We think that the numbers in many cases are significant enough that we are making intelligent judgements. By increasing the rates in bad areas, good business is chased away, both new and in force. We will continue to increase our rates to reflect the bad experience. Overall, we feel that some of that geographic experience is not necessarily the result of the quality of the policyholders alone but the quality of the medical practices, the expense levels of the community, the customs of the community and so forth. You are all familiar with these kinds of geographic variations.

We did an interesting study of the area where we had our very worst experience. The rates were well over double the rates for the country at large and over five times the rates for our lowest rated area. We found that a majority of the policyholders in that area had no claims. Of course, the ones that did, had big claims but there were still a lot of people holding on with no bad experience. We just could not afford to not charge these high rates, although there is the argument that every dollar that you raise the premium somehow loses you a dollar plus some cents. There is good business even in the worst areas if that is any consolation. We hope our agents find that business before your agents do.

MR. FERGUSON: Thank you very much. I would like now on your behalf to thank the panel and to thank you for your attention and your questions.