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GROUP INSURANCE UNDERWRITING AND SELECTION ISSUES

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1. Have group insurers changed their practice in response to recent financial results?

2. What are the underwriting and selection issues for non-traditional benefit programs such as cafeteria plans, Health Maintenance Organizations and alternative funding arrangements? What standards are being established for these programs?

3. What techniques are being used for monitoring the impact of underwriting policy?

MR. PAUL R. FLEISCHACKER: As we all know, there have been and are several environmental changes influencing the consumers, the products they demand, and the insurance industry's reaction. These environmental changes include high interest rates, high unemployment, high medical trend factors reflecting inflation, cost shifting, utilization increases, provider oversupply, medical technology, and increased competition among the providers resulting in alternative delivery systems, such as health maintenance organizations and preferred provider organizations.

As a result of these influences, the customer is demanding coverage flexibility, more cost sharing and cost containment features, funding flexibility for all benefit plans including their life insurance programs, and excellent service. The insurance industry, of course, must respond to these demands. Today we are going to hear about some of these responses and what underwriting changes have been made corresponding to these changes.

MR. ROBERT B. HARDIN, JR.: Today I am going to talk about the various alternate funding arrangements that are available for Long Term Disability (LTD) and Life Insurance. I will be discussing a wide variety of arrangements. Probably no single insurance company provides all of the possible arrangements - in fact some of the options do not require the participation of an insurance company at all. Nevertheless, this discussion will take place from an insurance company's point of view, with the company providing some insurance or acting as an administrator of an Administrative Services Only (ASO) Plan.

The marketplace for large groups appears to be shifting from a traditional insurance emphasis toward ASO Plans for disability income and toward other non-traditional arrangements for Life Insurance. Employers seem to want to participate in the investment risk associated with these coverages. This desire has been fueled by the high interest rates in the past few years. Generally, this is accomplished by allowing employers to retain all or a portion of either the positive cash flow generated or, equivalently, the reserves associated with the plan.

In addition to that, many employers want to participate in the insurance risk. They want to see low claim experience reflected in their bottom line immediately and seem to be willing to assume the risk of high claims. There is some desire to be protected against extremely high claims by using some sort of stop-loss vehicle. Most do not want to assume any extracontractual risks.

Requests are coming from smaller and smaller employer units. Self-insurance is common for relatively small groups for both Medical and Dental coverages. Brokers and employers are expanding the concept to other coverages. The major question to be addressed in this area is "What form of risk and investment participation is in the best interests of a particular employer, the plan participants and the insurer?" As insurers, we must protect ourselves while still providing the services that make up our business. In addition, we must be ready to protect the other two parties at interest - even if this means protecting the employer from himself. The challenge then becomes to find ways - products if you will -that meet the needs and desires of all concerned. The rest of what I have to say concerns ways that various insurance companies have developed to meet those needs. I will summarize the methods and how one might evaluate their appropriateness in a particular situation.

There are two extremes available. One is the fully insured plan which has been the traditional approach for both Life and LTD Insurance. The other extreme is the fully self-insured approach with or without an insurance company involved to handle details such as paying claims and calculating reserves. The options between these two extremes are not linear. A wide variety of possibilities exist, some of which are unique to LTD and some of which are applicable to any coverage. These options can be used separately or together. Most of them are already in use for Medical and Dental plans and thus may be familiar to you. Some options are useful for any size group and any coverage, but many are available only to financially stable groups with plans that have high credibility. The group's credibility will be a function of size, the type of coverage and the benefit schedule; or it may be a function of the number of expected claims.

The most common approach is still the fully insured plan with some experience rating refunds. This can be modified in a number of ways. The modifications are appropriate for almost any coverage but not necessarily for any employer.

A. The credibility of the group can be increased by pooling certain coverages (e.g., Accidental Death) or high amounts (e.g., amounts of Life Insurance over $50,000) or disability benefits after a certain duration (e.g., 5 years). The alternatives would be chosen to allow the non-pooled coverage to be experience rated with the smallest possible credibility pooling charge.

B. A second alternative would be a retrospective premium arrangement. In return for an agreement that when claims are "high" the policyholder will pay an additional premium, the insurance company agrees to charge a lower premium rate and/or to make no credibility pooling charge. This might be done with or without an advance deposit.

C. Related to the retrospective premium is an arrangement where the premium refund (in the event of good experience) is withheld and placed on deposit in a claims fluctuation reserve to protect against adverse claim experience in the future.

D. There is a wide variety of minimum premium plans. They involve the policyholder paying premiums equal to the insurance company's operating expenses and risk charge on a monthly basis with additional premiums directly related to claims and claims expenses as they occur. They normally include a maximum premium payment. The problems with this approach are month to month fluctuations, carry-over losses, incurred but not reported (IBNR) claims and waiver of premium claims.

E. Perhaps the easiest way of allowing the policyholder to participate in some of the investment experience is to allow a long grace period. This can be done in a way that allows the policyholder to invest the IBNR reserve. For example, a two month premium delay can allow the policyholder to hold on to funds that might approximate the IBNR reserve associated with a Life Insurance contract.

F. Another way to allow the policyholder to participate in investment experience is to remove the waiver of premium benefit from a life insurance contract. This will reduce the reserves held by the insurance company; the policyholder will be able to use those funds. One problem with this approach is that a replacement carrier may be required to waive the actively-at-work provision in the new contract. It could make moving a small case very difficult.

G. The insurance company may credit (or actually pay) interest on either the reserves or the positive cash flow generated by a group insurance policy.

H. The insurance company may allow the policyholder to provide securities in lieu of reserves. This allows the policyholder to control and presumably profit from the investment of the reserves.

All of the last three items may require an increase in the insurance company's retention formula if the company had previously been charging less for expenses because of interest earnings.

I. The insurance company might experience rate similar small policyholders as one larger unit to allow them to share in each other's experience. We have seen this in a number of small cities in California who have joined together in what are called Joint Power Authorities. This is related to association case underwriting, which has a different set of problems that I do not intend to discuss today.

It is possible to insure one part of a benefit plan and self-insure the other part. This is done by any policyholder who has an insured LTD Plan and a sick-leave plan. We currently see policyholders who wish to insure only the tail of a LTD Plan - the last 5 years. We also see policyholders who wish to insure the early part of an LTD claim and self-insure the tail in order to be able to keep the reserves associated with the long-term claim.

Some insurance carriers are offering a LTD Deposit Administration Plan much like a Pension Plan Deposit Administration Plan. This may even have a stop-loss arrangement on an aggregate basis.

Life insurance is harder to self-insure because of the tax consequences. Any benefits paid directly by the employer in excess of $5,000 will be taxed as ordinary income to the beneficiary. This unfavorable result normally prevents self-insurance by a typical employer. The need to provide both a conversion policy and settlement options also makes it difficult to self-insure Life Insurance. I have seen an example of a city that decided to self-insure a Life Insurance plan. The results were disastrous - claims during the first few months exceeded 10 years of premiums, and I am sure the tax consequences to the beneficiaries caused no end of trouble for the city fathers.

The last alternative is a fully self-insured plan. An insurance company should be able to provide all of the services that the policyholder desires. These services could include claim payments, document writing, actuarial services, and investment services. The employer will keep final authority on claim decisions and investment decisions. With this authority comes the responsibility to assume the extracontractual liability.

With all of these various alternatives, how does one evaluate the possibilities? From the insurance company's point of view, there are a number of issues:

A. When determining what plan to offer, the insurance company must consider a number of items: The potential market available, that is, "What can you sell?"; the effect on surplus (e.g., can delayed premiums under a minimum premium LTD Plan be treated as an asset?); the ability to administer the plan; the effect on other plans being offered. Profitability is a critical issue. Charges must take into consideration expenses, risks assumed, investment results, tax consequences, and development expenses. ASO charges should not be calculated on a marginal basis, although I have seen proposals that make me believe some ASO costs are being so calculated.

B. In addition to all of those rather traditional issues, the insurance company needs to be concerned about the long term health of the plan. That includes concern about the financial stability of a policyholder. Are they able to assume the maximum liabilities that the plan is likely to generate? Liability at plan termination time is a particular problem. If the policyholder should go bankrupt, is it possible that the insurance company will be the "deep pocket" that the courts will turn to if there are claimants with unmet expectations? We need to encourage, if not require, the full funding of claim reserves. Beyond that rather self-serving viewpoint, we have a responsibility to the plan participants. While we cannot guarantee the long term benefits, we need to be sure that there is a high probability that the benefits will be paid. This means that we need to be careful to whom we help provide fully Self-Insured Plans. While my company has not yet been hurt, we have had one partially self-insured LTD client go through Chapter 11 even though we are rather conservative in our underwriting approach.

C. The final issue is protection from extracontractual risks. If there is a large punitive damage lawsuit, who is liable? When is it appropriate to try to move the risk to the employer? Should an insurance company be responsible for its own negligence? Can it avoid that responsibility? How? Is it possible for the insurance

company to prepare a hold-harmless agreement that the employer will sign and that will move the extracontractual liability to the self-insured employer? If not, is it possible to charge for the extracontractual risk? What is a reasonable charge? These are difficult questions that do not seem to be obtaining appropriate attention.

Naturally, there are a number of considerations from the employer's point of view also. Many of them mirror the insurance company's concerns. Is the risk assumption (including extracontractual risk) appropriate for this employer? What is the cost (both direct and indirect)? What about the termination liability problem? What happens when a change in funding arrangement is desired - will the employer be able to fund the remaining uninsured claims (if not fully funded) and still pay for the new funding vehicle? What is the effect on the employer's profit and loss statements?

In addition to financial consideration, the employer will be concerned about employee protection and satisfaction over both the long term and short term. The issues here are plan administration and communication, the quality of claim administration, and the tax consequences on the benefits. Disability income requires a competent third party claim administrator if not insured. Flexibility of plan design could be an issue, although I am unable to think of a good plan feature that a large employer could not obtain in an insured plan. There are very few Insurance-Code-mandated LTD benefits.

In summary, there are many different ways to fund both Life Insurance and Disability Income Benefits. The issues are not simple - the typical employer will need competent advice in order to find the way through the maze to the right alternative. We, the insurance industry, should be able to satisfy the reasonable requests of employers, although we will occasionally disagree on what is reasonable.

An interesting question for the industry to ponder is "Are there any real savings for employers who move away from traditionally insured plans?". There may be premium tax savings in some states, although the various state Insurance Departments will be reducing the availability of that savings over the next few years. A California court recently ruled that all of the paid claims in a partially self-insured medical plan were premium. Beyond that, are there any savings? If there are savings, why? Are insurance companies overcharging for their services or for the risks that they assume? Can employers invest the funds better than an insurance company? Suddenly we see employers with options. Will this make us more responsive? Yes, these plans will be good for the industry in the long run, although I anticipate some interesting problems in the short run.

MR. PAUL E. HANSEN: My presentation today consists of the responses from a 1982 Blue Cross/Blue Shield Association group rating and underwriting survey. To stay within the bounds of this session, my comments will be concentrating on the underwriting responses from the survey.

No specific Plans are mentioned in the survey or in my discussion. This is an overview of all Plans, and you will note from the results there is a wide variation throughout the nation. This is a picture of the current activity and will not provide any trend information, although it is assumed that there has been change in the Plans' practices in recent years.

On the whole, approximately sixty-eight Plans have responded to the survey; not all questions were answered by the Plans. I will attempt to indicate how many Plans responded to any particular question as we proceed through the information. I will be concentrating particularly on the initial rating of groups and how the Plans underwrite them.

This first table shows what the minimum group size is for requiring prior experience in performing initial rating. For example, 29% of the Plans require a minimum size of fifty for obtaining prior experience. Sixty-two Plans responded to this question. The remaining plans have either no requirements or state that, generally, data is unavailable.

Table 1: PRIOR EXPERIENCE REQUIREMENT

Minimum Group Size	% of Plans
10-20	3%
25	5%
50	29%
100	39%
150-250	6%
500	6%

In Table 2, it is shown that a vast majority of the Plans give a 12 month rate guarantee with some Plans having exceptions between 10 months and 18 months. Sixty-two Plans responded to this question.

Table 2: PERIOD OF RATE GUARANTEES

Number of Months	% of Plans
12	88%
15	3%
OTHER (10-18)	9%

In the survey 18% of the Plans used small group medical underwriting. Sixty-three Plans responded to this question, where the minimum number of lives for non-medical underwriting varies between 2 and 15, the minimum average is 8.6 lives.

The range of number of lives required for 100% participation in a group varies between 3 and 49 lives with a highest level concentration being in the 4 to 5 life and 9 to 10 life range. Some Plans allow for 100% minus 1 arrangements and others 75% participation. Allowance for lower participation limits on renewals is common.

Sixty-five Plans responded to the minimum employer contribution questions. You will see in Table 3 that the results are quite evenly spread from 25% to 100% contribution for singles. For family, the contribution level is linked to the single rate. Some Plans vary their contributions requirements by group size.

Table 3: MINIMUM EMPLOYER CONTRIBUTION

Minimum Contribution	% of Plans
Single	
25%	23%
50%	37%
100%	37%
Family	
50% of Single Rate	26%
100% of Single Rate	35%

When prior experience is not available but required, three Plans will not quote rates. Thirteen Plans use manual or community rates with no adjustments and fifty-one Plans will use adjusted rates from their manual or community values. These rates will be adjusted by demographics. Sixty-seven Plans answered this question.

Of the fifty-one Plans that use demographic adjustments, the minimum size on which these adjustments were made correspond with the data in Table 4.

Table 4: ADJUSTED MANUAL RATES

Minimum Size	% of Plans
5	10%
10	10%
25	16%
50	27%
100	20%
300	2%
ALL OTHER	6%

From these same fifty-one Plans, the demographic factors used consist of the categories in the following table. You will see that age, sex, and area are by far the most dominant. Nine of the fifty-one Plans use substantially all of these factors, of which seven of the Plans concentrate on the use of age, sex and geographic area. The balance of the Plans use a combination of one or two of the above.

Table 5: DEMOGRAPHIC CATEGORIES

Category	% of Plans
Age	86%
Sex	73%
Industry	57%
Participation	33%
Contribution	47%
Geographic Area	75%
Other	10%

In using initial rates for community rated groups, the following demographics are used by the Plans respectively. Notice that age and geographic area are the most dominant, with sex and industry following closely behind. Eight Plans use the top six categories and the balance of Plans only look at three or less.

Table 6: COMMUNITY RATING DEMOGRAPHIC CATEGORIES

Category	% of Plans
Age	86%
Sex	68%
Industry	61%
Participation	43%
Contribution	50%
Geographic Area	82%
Other	11%

When the Plans were asked about renewal rating for community rated groups and whether or not demographic factors were used, thirty Plans responded by saying they do. Table 7 shows the distribution by category. Notice that substantially fewer Plans use demographics for renewal rating. Geographic area and loss ratio are the dominant categories. Please note that loss ratio is used by some Plans in determining renewal rates for community rates. However, the Plans that did use this kind of rating tended to use all of the categories. It is assumed, although not specifically stated in the study, that those Plans using the rating factors shown in Table 6 also use renewal rating factors in the same way, with the addition of the loss ratio category.

Table 7: RENEWAL COMMUNITY RATING DEMOGRAPHIC CATEGORIES

Category	% of Plans
Age	50%
Sex	46%
Industry	29%
Participation	25%
Contribution	25%
Geographic Area	55%
Loss Ratio	58%
Other	4%

Table 8 presents the regulatory approval that is required of the Blue Cross/Blue Shields Plans. Sixty-eight of the Plans responded to this question. These are requirements for the approval of rates, factors, and formulas that are not normally imposed upon commercial carriers. The majority of Plans need to supply more than one of the shown categories.

Table 8: REGULATORY APPROVAL

Category	% of Plans
Community Group Rates	56%
Community Group Formula	58%
Community Group Factors	40%
Experience Rating Formula	57%
Experience Rating Factors	25%
New Benefit Description	82%

Finally, Table 9 presents the flexible cash flow arrangements that are currently being used by the Plans that were responding to the survey. The second line is where the advanced deposit is less than normally required. The third line, contingent premium arrangements, is whereby the account is liable for an additional premium charge at the end of the contract period if the premium paid during the contract period proves to be insufficient to cover claims payments and retention charges. The deferred premium category is where the monthly premium payments are due at a later date, either 30, 60, or 90 days after the normal monthly premium due date. The "other" cash flow arrangements shown here generally involve a variation of cost-plus arrangements.

Table 9: FLEXIBLE CASH FLOW ARRANGEMENTS

Category	% of Plans
Cost-Plus Without Advance Deposit	49%
Cost-Plus With Advance Deposit	34%
Contingent Premium	46%
Deferred Premium	32%
Other	18%

MR. CHARLES C. DeWEESE: I would like to talk about the financial aspects of experience rated group health programs, some of the changes that have taken place in the last year or so in that market, and what underwriters have done about those changes in order to respond to the financial environment. I would like to begin with an illustrative story. When I went to breakfast this morning, I approached the head waiter who was standing in front of a gate. He wrote down on his pad that I was there and said, "Okay, follow me." He then turned around and walked into the gate. One of the things I learned as an actuary in the group insurance business is that I should examine the consequences of any intended action before I do what I am told. I did not follow him into the gate.

To start off with, the group business has been a very good business for many companies over the last ten years. There has been tremendous growth in premium volume and profits for the most successful carriers. These successful carriers followed what I call a strategy for profit. The most important aspect of that strategy is maintaining responsible and responsive rating - taking account of changes in the environment and doing it on a timely basis. When I was a group pricing actuary, my maxim was: "When in doubt, charge much and when in much doubt, charge more." That worked quite well for me.

Another aspect of this strategy for profit was the careful management of deficits. First, make sure that you do not have too many deficits. This ties in with charging much in the first place. You will obtain some deficits because you cannot charge enough to avoid them always. Even properly rated group cases experience fluctuations, so you will have cases that run into deficit positions. When you have them, you have to make sure they stick around and pay you back in future years. The successful companies underwrote for persistency. They explained upfront what the procedure was and that they expected their customers to stick around and pay their bills. When I first became involved with group business, this was a very fascinating phenomenon - customers who had no legal obligation to pay did stick around year in and year out and repaid their deficits. This is a very critical part of making money in the group business. There is a limited upside potential on a case that is in a positive position - you can make your retention minus your expenses and a little bit of investment income. However, there is much downside risk since you can lose all the way. The nice thing about deficit cases is that you have the potential to recover the deficit. There is much more profit potential in recovering a deficit on a case that was bad for you last year than there is in the margins you can make on a case in a positive position.

During the 1970's, another area that was very important to insurance carriers was holding other people's money. Carriers did that in the form of claim reserves that were often larger than the underlying claim liability. Also, when they could obtain them, and they could obtain them quite frequently, carriers would establish stabilization funds which acted as additional margins. These carriers, who did well from a profit standpoint, developed much capital during the 1970's, and that allowed them to become very competitive marketers as well. You may wish to read "The Group Insurance Myth" and "The Group Insurance Myth Revisited" - articles by Peter Walker which state that the most successful carriers are successful both in the profit area and in the marketing area. Those carriers have had both the highest profits and the highest growth, contrary to some of the popular wisdom which said that you cannot do both.

There are three factors that affected health insurance during the last ten years: inflation, high interest rates, and new products. Inflation is probably the one that has received the most attention and has been widely denounced as a villain by the insurance industry as well as the buyers of insurance. It certainly made the health insurance business very challenging for actuaries and for anyone else concerned with profits. However, inflation was the best thing that could have happened to the group health insurance business. The effect of inflation was that premiums were indexed for a very high level of trend. Retention charges that were often expressed as a percentage of premium were similarly indexed. Profits grew quite rapidly by being tied to the premium base in a business where the market was basically saturated.

Throughout the 1970's, but especially in the mid to late 1970's, the advent of high interest rates created a cash squeeze for employers. Sensitivity to the cost of money resulted in employers becoming interested in obtaining "their" reserves. Many group carriers had been keeping the interest earnings on claim reserves to offset expenses or to augment risk charges. When policyholders became interested in obtaining a meaningful return on those reserves, the insurance companies were in a position where, because of taxes, they could not pay a very high rate on reserves even if they wanted

to. The pressures became quite extreme. Several methods were developed for returning those reserves to policyholders. One method was the deferred premium or delayed grace period where policyholders could wait three months to pay their premiums. This approximated the length of the claim lag and approximated the size of the reserves. Some of the other methods which were developed for the same reason of "freeing up" the reserve and putting the business on a cash basis were ASO and minimum premium plans.

In the product area, dental insurance was the new product of the last ten years and represented a pure opportunity for carriers who were prepared to deal with it. It required a great deal of capital because, in writing new dental cases, there were significant early losses since the rating was very competitive and actuaries did not have good experience information. It also required substantial capital for systems development. The carriers that were aggressive in the market obtained a large and enduring market share and found that they were able to recapture early deficits over a period of a couple of years.

While nothing profound has happened regarding the changes in the group insurance market in the last year or so, there were many underlying influences, which existed for a long time, that came together and became more severe. The most serious challenge in the last two years was that the group business has experienced the highest medical care trend ever. This resulted from increased utilization and the general economy. Lay-offs have a very bad effect on health insurance business - as people become laid-off, the premiums associated with those people go away, the claim levels increase as people anticipate losing their coverage, and the demographics of the remaining group deteriorates because the youngest employees tend to be laid-off first.

Another effect that has recently caused greatly increased medical care trends is Medicare and Medicaid cost shifting. Because the federal government is paying a smaller share of provider costs, hospitals and other providers have had to raise their prices to the private sector to compensate. A number of companies were surprised by how quickly and how hard that hit. It caused many companies, even the ones who had been successful and had growing earnings all through the late 1970's, to see a reversal in that earnings trend in 1981-82.

Another change, which is more of a fundamental change in the character of the group business, is that there has been a break-down in the cozy relationship that companies had with their customers. Five years ago when I was at Connecticut General, 5% was about the average lapse rate experienced on the non-jumbo block of business. Lapse rates are much higher than that now in all blocks of business for a wide variety of carriers. Because the customers are squeezed for cash, they are looking for the lowest price they can obtain. There has been a break-down in the old loyalty that enabled carriers to keep their customers on the hook to pay off deficits. Nowadays, many customers are more hard-hearted about staying with the current carrier to pay off deficits when they know they can start over again with another carrier.

A more gradual change in the group business is the development of more ASO business and other alternative funding arrangements where policyholders are holding the reserves. This creates a new type of financial risk for insurance carriers. Besides this financial risk, there is not much of

that good old OPM (Other People's Money) left to earn investment income on.

Also, interest in cost containment has greatly intensified. While that has not had a direct financial impact on the insurance carriers, they have had to change the way they do business. Customers are demanding and receiving more information about their claim activity since many customers are beginning to realize they have to be actively involved if any cost containment efforts are going to work. Over the course of the last five or six years, there has been much wringing of hands about how cost containment has to be developed. There have been some good ideas, but there has not been anything that approaches a solution because two parts of the group insurance triangle - the providers and the carriers - have not had much financial incentive to work on it.

In the more difficult environment that has existed during the last few years, the successful group underwriters are really sticking to fundamentals. Remember my maxim that when in doubt, you charge much. From a survey I conducted about a month ago, trend factors that are now being used range from 19-24% annually. I do not recall who was at 19%, but he was very apologetic about it. He was going up.

In addition to currently charging trend at a high level, companies are reviewing trend on a very formal, monthly basis. They are being very careful about considering external impacts on their costs. A few carriers have even gone to rate actions more frequently than annual when they think there is a need for it.

Insurance companies no longer have the financial buffer of all those reserves. I remember some cases which cancelled in a deficit position. By the time the claims ran out, the reserve more than covered whatever that deficit was. So, while the underwriter might initially have felt bad about losing the case and having to swallow the deficit, very often the reserve levels were enough to pay that off. Now that those reserves are not there, insurance companies can very often be in the position of paying out some claim money before they obtain the premiums. Insurance companies have gone to much more careful financial underwriting including Dun & Bradstreet checks and their own internal credit checking mechanisms. Many companies are doing this annually on all their business, not just new cases.

The increased turnover among the client base has caused underwriters to stick much closer to book rates and book margins. Underwriters who previously were willing to take a chance on a situation in the hopes that if it went bad they could catch up next year, are not taking those chances. In situations where deficits exist, they are treading very lightly because their customers have many options to move.

Carriers who, in the past, had always been willing to amortize deficits over a period of years are now trying to collect them as quickly as possible. Other carriers who had always insisted on obtaining deficits right away are now amortizing them so that policyholders will not feel too bad. No one seems to be forgiving deficits totally. Another method of dealing with a case in the deficit position where the company still holds the reserves is to send the reserves back to the policyholder in exchange for a letter of credit, deduct the deficit from the cash transfer, and retire that deficit. It is a one-shot deal that some companies have used and cannot use again. Once the reserves are gone, they do not come back.

Finally, underwriters are paying attention to cost containment more than they have in the past because they have the feeling that the customers are serious about it this time. They have instituted new systems to provide more data. They have been introducing different benefit programs and modifying existing benefit programs so that the programs will be more conducive to cost containment. In the past, where there were benefit revisions in existing programs, the changes were always liberalizations. Now, the customers and the carriers are working together. Virtually every new benefit revision is a restrictive one with more emphasis on cost sharing in the hopes of controlling utilization. If utilization is not controlled, at least the employee will bear some share of the costs.

MR. HOWARD J. BOLNICK: To begin, we need to clarify that when we talk about small groups, we are discussing employers with anywhere from one to roughly fifteen employees. At these sizes, it is easy to agree that the employer often knows about any serious health problem of most, if not all, employees and their dependents.

Over the past few years, I have had a number of opportunities to discuss and analyze small group medical expense programs and their problems at various Society meetings. On each of these occasions, the discussion was based on qualitative information alone. This was necessary since I had not had access to any experience data specifically designed to provide an analysis of small group programs and collected over sufficient time to provide meaningful results. In fact, throughout the years that I worked as a consultant to small group programs, I found not a single instance of a data gathering system designed to analyze the underlying reasons for the alarming number of plan insolvencies, outsized rate increases, and benefit reductions that constantly keep small group insurance in the public eye.

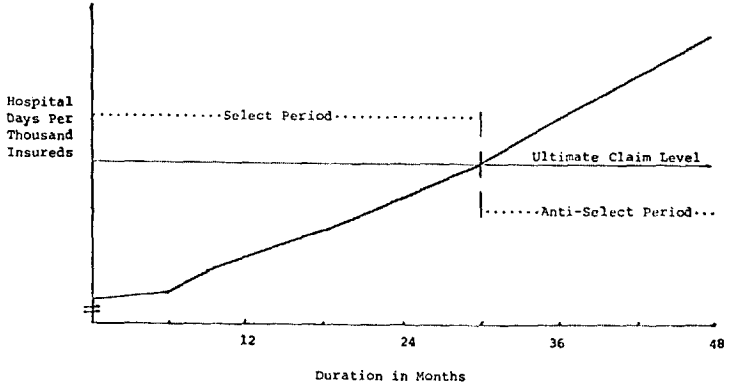
Over the past two and one half years, I have been involved with the design and implementation of a very successful small group program: The Horizon program underwritten by Celtic Life Insurance Company and administered by Plan Services, Inc. of Tampa, Florida (a wholely owned subsidiary of Dun & Bradstreet). A major criterion in the design of this program was that the insurer and the administrator be able to constantly exercise complete control over the rates, benefits, administrative matters, claims, etc. The basic means of exercising control was to develop a sophisticated ability to gather and to analyze incurred claim and corresponding premium information. Detail experience information has allowed us to quickly and accurately identify our mistakes and to correct them before they become costly errors. Detailed information has also given us a clear picture of what happens with a block of small group business which too often sows the seed of problems plaguing these programs. It is this new-found quantitative understanding that I would like to share with you today.

Small group programs are made up of a large number of small units - the participating employers, their insured employees and dependents. Each participating employer has the right, at any time, to choose to remain in the program or to leave it. In fact, it is common to find small group programs having 3-4% of all participating employers lapse each month. This is equivalent to one-third to one-half of the employers making up the small group program leaving each year.

Following a number of employers, all of whom joined the program on the same date, throughout time we notice two trends take place. First, the benefit of any initial underwriting wears off relatively quickly. Second, the employers terminating their participation in the program tend to be the healthier groups. This means that those employers remaining in the program can easily exhibit a rapid increase in the incurred claims. Chart 1 illustrates this aging effect using data drawn from our own small group experience combined with data derived from government statistics and Society of Actuaries studies of experience under individual health insurance policies. Our program uses a non-medical health questionnaire with three carefully designed questions, but no Medical Information Bureau reports (MIB's), no attending physician statements (APS's), and no health condition waivers.

We use hospital days per thousand insureds (employees, spouses, and children) as our measure of the incurred claims associated with the employers in a cohort. Hospital days per thousand increase rapidly from issue to an "ultimate" level after about thirty months. "Ultimate" represents the number of hospital days that would be experienced if a random sample of people were chosen from the non-institutionalized working population with an age and sex mix matching that characteristic of our small group insureds. Differing underwriting strategies result in other starting points and varying lengths of time until the "ultimate" level is reached. For instance, a guarantee issue program with a full waiver of any pre-existing condition limitation would begin at, or near, the ultimate hospital days per thousand.

Chart 1 - Aging Curve



We have discussed only that portion of the chart up to the time that the "ultimate" level is reached. That is, the select period. However, this is merely the "tip of the iceberg." The phenomena occurring after "ultimate" is reached has been described by William Bluhm in his paper "Cumulative Antiselection Theory (CAT)." Briefly, CAT holds that as insureds, or in our case, participating employers leave the program, the remaining employers and their insureds have worsening experience. This happens because participating employers with healthy insureds are more likely to be mobile than

those with unhealthy insureds. With 3-4% monthly lapse rates, there is a great deal of mobility among small employers. We all are certainly aware of the reluctance of an employer to switch carriers because "the boss' wife has a heart problem." Simply stated, it is this type of employer who tends to stay in a small group program.

The consequences of this tendency are simple to describe. Incurred claims per unit within a program increase with time for three separate reasons:

1. Initial underwriting, if any, wears off,

2. Cumulative antiselection takes place with the relative attrition of healthly groups, and

3. Medical expense care inflation raises the cost of services rendered.

Incurred claims per unit, then, increase faster than inflation. How much faster depends on the mix of new business to aged business and on the actual effect of the aging process on incurred claims. For rapidly growing blocks of business, incurred claim increases in excess of inflation cost may be relatively small. But, for aging block of business, the effect can be quite marked.

A model can be constructed which demonstrates this aging process for an underwritten small group pool. Assume a constant 10% annual cost inflation, level monthly production, a 3% monthly lapse rate, and incurred claims increasing 2.1 times from issue through the thirty-sixth month and staying level thereafter. The resulting increase in claims cost from all sources is 26.9% in the first year, 20.7% in the third year, and 12.8% in the fifth year. All of these figures compare to an inflation based increase of only 10.0% per year. The decrease in overall claims increase relative to inflation reflects a theoretical tendency towards a stable population which is inherent in our model. However, this theoretical stability rarely seems to be characteristic of small group programs. Underwriting techniques and growth patterns which differ from that in our model significantly alter the yearly excess increase in incurred claims.

The lesson from this over-simplified example is clear. With time, incurred claims will increase faster than expected due solely to inflation. This increase is a natural one, but one that cannot mindlessly be matched by corresponding rate increases without potentially serious consequences.

A careful review of past experience with deteriorating small group programs shows that large rate increases tend to reduce production of new business and to increase the exodus of healthly employers to other low cost small group programs. The mix of business remaining following a large increase is, then, worse than the mix preceding the rate increase. After a large rate increase, a program will have less new business and relatively more unhealthy employer groups. This change in mix can easily become an "assessment spiral" where ever-increasing rates chase ever-worsening claims experience.

The "assessment spiral" phenomenon is not simply a theoretical argument. Perhaps the best documented history of the reality of this phenomenon was recently circulated to Society members. I refer you to Alan N. Ferguson's discussion of what he calls ". . . a rather sorry tale of Prudential's experience with . . .'Coordinated Health Insurance Program (CHIP)'." The

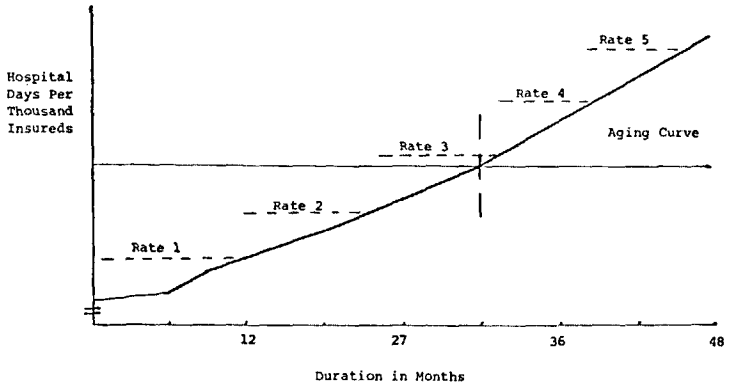
discussion is in The Record, Volume 8, Number 4, page 1203. Prudential's "sorry tale" is only one of literally dozens of "sorry tales" that could be told by both insurance companies and uninsured small group programs. In fact, this phenomenon is so wide-spread that many observers fear that an assessment spiral will be the inevitable final gasp of almost any small group program.

Is there anything that can be done to avoid an assessment spiral and provide the long-term stability sadly lacking in small group programs? Yes, but it requires a well thought-out response to the inevitable aging process in the underlying experience that we discussed earlier.

Super-impose a few alternative pricing and underwriting strategies on our original aging curve and demonstrate the problems inherent in designing a strategy to cope with the aging process.

Alternative I: Price your product as low as possible and bring rates for all participating employers up as fast as required by the deteriorating claims experience. This approach has been used, often inadvertantly, by a large number of insured and uninsured small group programs almost always to no good end. Rates start out quite low, drawing a great deal of new business. Rates begin to increase with time as the aging process takes hold. Rate increases begin to increase with time as the aging process takes hold. Rate increases begin to dry-up new business causing a further unfavorable change in the mix of new to aged business. And on and on, until the process turns into a full-blown assessment spiral. I estimate that this alternative strategy in the hands of unsophisticated managers will almost certainly result in the program's demise in three to five years.

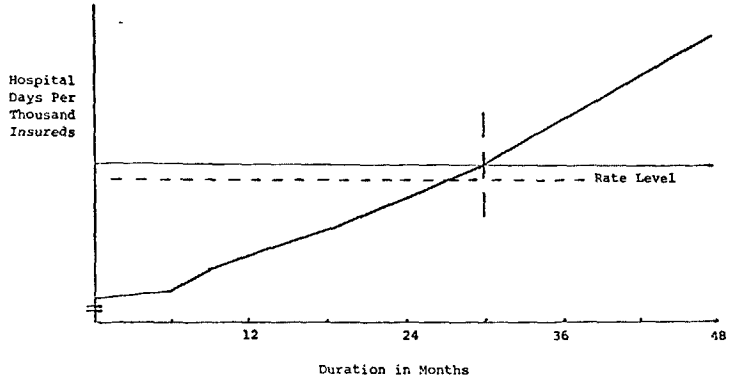
Chart 2 - Alternative I: Composite Rates



Alternative II: Price your product at or near the ultimate rate level. This strategy is not particularly marketable since it emphasizes uncompetitive rates. The little new business that is written will be

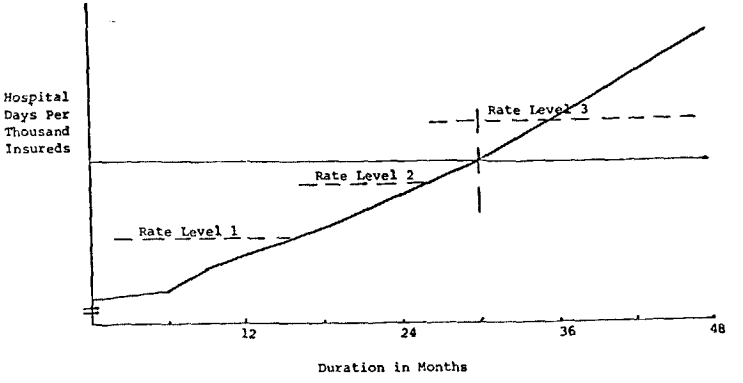
very profitable, particularly if it is underwritten business. However, the seed of an assessment spiral is only delayed through high initial rates and not eliminated. Eventually, the mix of new to aged business can become so unfavorable that even a high rate level may be subject to large rate increases and subsequent accelerating deterioration in claims experience. Prudential's CHIP program appears to ultimately have been a victim of this strategy.

Chart 3 - Alternative II: Single Rate Level for All Groups



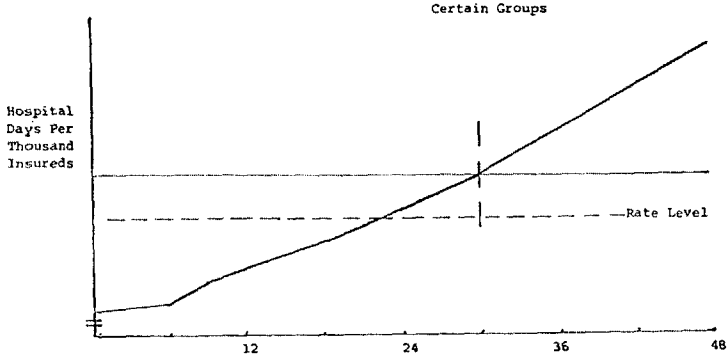
Alternative III: Use a select and ultimate rating scheme. This strategy has the advantage of encouraging new business while charging aged business a rate reflecting its own underlying experience. The major problem inherent with this approach is that it reinforces the aging process by encouraging healthy employer groups to either enroll to obtain lower rates or to seek coverage elsewhere. Thus, an assessment spiral can more easily set in at the higher rate levels.

Chart 4 - Alternative III: Rates By Duration from Issue



Alternative IV: Use a uniform rate level for all business, but retain the right to non-renew selected participating employers. This alternative strategy, in effect, substitutes selective terminations, generally of aged business, for rate increases. Problems with this approach include difficulties in identifying unhealthy employer groups for termination and potential legal, regulatory, or marketing barriers to selective renewal actions.

Chart 5 - Alternative IV: Single Rate Level Termination of Certain Groups



A well thought-out program based on Alternatives III and IV has the best chance of becoming a long-term, profitable small group program. Select and ultimate rating supports a viable marketing program while addressing the aging effect head-on by isolating aged business within the overall program. A program of selective terminations, particularly at higher rate levels, can then provide the back-up protection needed to control the now isolated aged business exposure.

I suggest that you, as managers of small group programs, carefully study the effect of the aging process on the long term stability of your programs. A failure to do so will raise the risk that your program will ultimately become another on the long list of embarrassments to the insurance industry.

MR. FLEISCHACKER: At the Philadelphia meeting, Jerry Winkelstein from John Alden Life Insurance Company gave a presentation regarding their mini-group program and the renewal pricing strategy that they use. It might be considered as Alternative V. Basically, they segmented their business into select and substandard blocks. Groups that had loss ratios within one range, less than 100%, were considered their standard block of business. The second segment was one that ran from 100-150%, and was labelled substandard block one. They gave that segment a 25% load over their standard rates. The final group was anything above 150%. They rated this part at 100% above standard. The group had to have poor experience over a two or three year continuing period rather than a single one year of experience.

Is there any other company that would care to share what they are doing on their mini-group? Any questions or comments for any of our panelists?

MR. DAVID CRESWELL: Concerning what you just mentioned about reviewing the loss ratios on smaller groups, our underwriters will pay more attention to the claim files on groups that size than they will to the loss ratios. The choice to either non-renew or put a higher premium on groups of this size would be based more on a diagnosis that looks to the underwriter like it is something that could blow up in their faces later on. On groups of this size, the loss ratio more likely than not has resulted from either random fluctuation or somebody who is already disabled - in which case, even if you terminate the group, you are going to be stuck with the claims.

MR. BOLNICK: I would like to make two comments. One is that the fifth alternative that Jerry Winkelstein at John Alden is using is, in fact, an alternative. The four that I am suggesting are just outlines. In reality, some combination of them is what you want to do. The Alden approach is just another way to arrive at the same type of problem. Secondly, Dave, what you said about addressing the claim files as opposed to the loss ratio cannot be emphasized enough. The problem group is the one that has a 55 year old who is hypertensive and going to have a heart attack next year. The problem is not the group with the 2000% loss ratio where there was an auto accident and the person is back to work. When we are judging groups, we very strongly emphasize what the diagnosis of the claim is - regardless of the size of the claim - as opposed to emphasizing what the loss ratio is.

MS. BETSY UZZELL: Some time in 1981 or 1982, there was a law passed by Michigan which said that we could not make any modifications in rates due to type of occupation. For those doing business in Michigan, what are you doing in the under 50 life group market?

MR. BOLNICK: One of the problems that I mentioned in the select and ultimate or in the termination alternative is the possible regulatory problem. Most small group programs are really using what is called a Multiple Employer Trust (MET). That usually means so many bad things to people that I have learned to stop calling them MET's and start calling them small group programs. However, what you are faced with is choosing a state of situs of the trust that will allow you to do those things that you feel are necessary. Most responsible small group carriers will then file their certificates for information purposes in the other states they are going to do business in and will only do business in states that they are licensed in to write insurance.

Most states take that as an information filing and do not give you a problem. For instance, our program is written in the state of Illinois. We filed for information purposes in the state of Michigan. The state of Michigan did not say anything to us about any of their benefit or other restrictions. In fact, if a complaint goes to the Michigan Insurance Department, they will refer it to us. We will answer that this is an Illinois contract and that is fine with them. So, we have not had a problem with Michigan. Now, if you want to write a program in the state of Michigan, you might have a problem if you choose to do something with rating that violates that regulation.

One thing that has resulted in many of the problems that have popped up in the last six or nine months has been insurance companies going bankrupt. Many states are beginning to care about out-of-state small group programs. In the past, they just gave a cursory glance.

MR. ROBERT C. NUDING: Our interest has been drawn not because of the suggestion of selective termination but because of experience rating of under 50 life groups and some notable extreme examples. I will mention only one. A small policyholder of 14 lives had had some adverse experience on several people - one of which resulted in death and the other resulted in an on-going claim situation. The premium rates were increased by 327% over a nine month period in two rate increases. Even though the state legislature is always very busy with a thousand bills being submitted by everybody, we have been receiving repeated calls from Assemblymen whose very sophisticated New York City clients are raising objections. So, to the extent that continues and is not done very well, probably something will happen down the road.

MR. BOLNICK: Yes, I agree. If you will consider the consequences of the aging curve and what has happened with a large number of small group programs, you can come easily to the conclusion that insurers in the business as well as small groups themselves are in a bind. What exists is a situation where a small group program is trying to do the same thing for everybody at all times and is probably going to fall apart - resulting in everybody losing their coverage. A group or program that tries to selectively do something with participating employers or classes of risks within a pool runs into some regulatory problem. The poor, bereaved participating employer is yelling, screaming, ranting, and raving about having been selected against or selected out for adverse treatment. It is a very serious problem. One of the major reasons that I wanted to come in front of the Society was to put in The Record what is really happening with these programs so various interested parties - the insurance companies, the regulators, the people who sell the small group programs - can start thinking about these programs and start really considering what is going on. It is a very sad situation which has been an embarrassment to the insurance industry over the past few years.

MR. PAUL W. ORMROD: In the last couple of years, we have had some disastrous results with our small case business. We studied it intensely and came to a number of conclusions. First, future rate structures should rate the case by age bands to avoid the problem of lay-offs being at the younger ages. Also, some type of audit of cases is needed to make sure that the participation stays up. In tough times, small cases tend to leave some people off the enrollment. Controlling the industries that are eligible for the trust period is important. In other words, we have a whole list of ineligible industries. We avoid 95% of the Third Party Administered (TPA's) and the other 5% are audited strictly and regularly. Finally, we try to monitor the results of individual brokers and the business they put with us. We feel that if there is any way that we can stay in the business, this may be it.

MR. BOLNICK: The type of actions you are talking about are going a long way toward solving the problems with small group business. Particularly important is the concept of watching what the brokers produce. It is an unfortunate fact that some of the brokers participate in placing known bad business with insurance companies. It does not take much bad business to make a whole pool bad. If you take a horrible small group pool, you essentially re-underwrite it by looking at the claim files. You will find that somewhere between 20 and 30% of all the groups have caused more than 100% of the problem, and the other 70% are probably just there for the ride. They are fine groups - good risks - making you much money. It does not take many bad apples to really destroy the integrity of the whole program, and it does not take many bad brokers to make that happen.

MR. DeWEESE: Howard, how would you suggest that those groups you call bad groups obtain coverage?

MR. BOLNICK: I have to admit I have some answers. Let me share some of them with you, but I do not have all the answers. If the entire insurance industry became "tough" with small groups and booted these bad groups out, then obviously, they would not be able to obtain any coverage. There are a number of answers. First of all, in today's environment there are carriers out there who are willing to underwrite bad business. That makes life easy. However, that means we are sticking our heads in the sand because hopefully they will obtain religion and do it right. Now, if they obtain religion, that means that there is no home for these people who turned bad or are bad.

The way I analyze it is two-fold: (1) there are some states that are putting together substandard pools for individuals who cannot qualify for health insurance on their own - rather than oppose that, I see some merit in it; and (2) if you have a bad group that you are stuck with as an insurer, you can take a detailed look at it. Let us assume you have four or five employees - that means you probably have ten to twelve people covered. Your problem is probably only one or two of the people. However, if you have a mechanism for providing some insurance for those one or two bad people who cannot obtain coverage elsewhere, you can come up with some creative solutions as to how to be sure that nobody will be left without coverage who legitimately needs it. A fundamental thing in designing these programs is that if you are going to take hard actions like terminations or heavy ratings, then you have to consider that you cannot eliminate, for example, that cancer patient who is out there flat on his back. You have to have some mechanism for taking care of them. Otherwise, it is very easy to be accused of being unfair. There are ways to do it - not just through the state governments but also within insurance companies through certain other types of pooling arrangements and conversion options.

MS. FRAN JONES: Mr. Bolnick, you described the individual underwriting in your small group program as being non-medical, three questions, and no APS. Do you have any idea on a quantitative or qualitative basis if the select period would be longer if you increased your underwriting restrictions in the beginning - a longer non-med or obtaining APS's or something along those lines.

MR. BOLNICK: No, it would not be any different. But, I have to qualify that in two ways. First, the three questions that we use really duplicate about 90-95% of the information you will obtain on an 8½" x 11" non-medical underwriting form. In other words, we have a very small card. There is much wasted space on those long non-medicals which tends to scare away agents. Second, there is a need to thoroughly investigate at claim time. If, at claim time, you are catching those who lied on the application, then the select period does not increase. We really do investigate. We ask for records from the doctors and from the hospital. It takes time and people become mad. But, it is worth doing because some people have lied. Now, if they lied and are caught, their claims are not going to be paid. That is simply what happens and it is very unpleasant. I am sure our friend from the New York Department can tell all sorts of horror stories about companies who abuse that privilege. Companies have to take care of people who make material misrepresentations. But, if handled properly, fairly, and honestly, it is something that enhances the whole program because it protects the people who tell the truth from those who do not.

MR. ORMROD: Mr. DeWeese made a comment that no one to his knowledge is actually going in and forgiving deficits. In a way that is what we are contemplating doing. We have decided that we do not want to price for the assumption that we are going to make up these deficits in the future. Therefore, we are forcing these people onto a cost plus with an aggregate stop-loss which really is the same as an experience-rated approach where you do forgive the deficits. As far as the groups that we have right now, we are going to be looking at these case by case. If we can keep them on a basis where the deficit or the contingency reserve that they have built up is maintained, then we will keep them on the same program they have now. We will do that only in the cases where it seems to be a better deal for us. In other words, they may have received a break on the contribution to surplus. If we are better off leaving them with that same break because there is a large deficit, then we will leave them in that position until the time the deficit is made up. Then, they will go into cost-plus. On the other hand, that is going to force us into a situation where, if they realize that they have the option to go into the cost-plus program, then we will have no choice but to forgive the deficit since if they leave, we will be forgiving the deficit anyway.

I am wondering if anyone else is doing this. Or, are people still moving toward pricing as if those deficits are going to be made up on the new business that they are now writing and on the business that is being renewed? Or, are prices being based on the idea that you cannot count on having the deficits made up?

MR. DeWEESE: Responsible carriers have never priced on the basis that the deficits would all be made up. There is recognition that they would obtain some of the deficits back. Most of what you are talking about doing is a prospective arrangement. Because it is all within the same company, customers will realize they have the option to enter that program. You are going to be exposed to a higher degree of lapse than you might otherwise have from your traditional program. But, any situation where you are able to charge extra money upfront against the possibility of deficits and then not have to collect those deficits is a good idea since you cannot count on collecting those deficits. That is the principle behind individual stop-loss. Anything

you can charge for a high deductible, individual, stop-loss plan was free money because, to a great extent, you could never count on recovering large claims. So, any charge you could make for it in advance was something that could be tucked into your pocket with much confidence. Your program is a good one. However, as you noted, you have exposed yourself to some extra risk of lapse on the deficit that you have now.

MR. FLEISCHACKER: A question to pose to both of you: Do you, in effect, factor in that risk of additional lapse into the risk charge that you are charging all groups?

MR. ORMROD: We do not factor anything in now because what has already been lost in the past is a sunk cost. When I was called on to reprice the experience-rated business, I could not develop any assumption about how much of the deficit was going to be recovered and really be confident of the assumption because I did not feel it was an insurable risk. My recommendation was that we cut our losses at this point and then go forward, ignoring the fact that those people might leave because I felt they might leave anyway.

MR. DeWEESE: I would agree with that, too. When I was pricing group insurance at Connecticut General, we set our risk charges at a level where we thought we would, at a minimum, break-even if all the deficit cases lapsed. There are many different ways you could juggle the pieces to see how much money you are making. If we never obtained any deficit recoveries, we could break-even. Then, the number of deficits that were recovered would construct the profit margin. In total, we had an expectation of recovering deficits and we tried to know how much that would be. We recognized that that was not an insurable risk.

MR. ORMROD: When I looked at what was being charged by my company on experienced-rated business, we had a contribution to surplus that was much too flat by size of case versus what you would theoretically need for an aggregate stop-loss. There were actually some size cases where we were in great shape even if we never obtained back deficits and other ones from where we would have to obtain back a great deal of the deficit to break-even. I wonder if this is not somewhat true of the industry as a whole - the curve of the amount charged to contribution to surplus on cases of different sizes is not as steep as it would theoretically be calculated to be.