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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. JEROME WINKELSTEIN: My name is Jerry Winkelstein, and I'm Vice-President and Group Actuary for John Alden Life Insurance Company in Miami, Florida. John Alden has specialized for over 14 years in the mini-group market; mainly writing cases with 2-9 lives. I expect this session to be especially informative and entertaining since joining me on this panel are three marketing-oriented actuaries. I say marketing-oriented since all three are currently employed by large third party administrators whose main function is to rate, write, and administer mini-group life and health business which will be profitable for their respective underwriting carriers.

An open forum consists of two phases: first, each of the panelists will give a brief 15 minute prepared presentation; after that, the remainder of the session will consist of a lively question and answer session between the panel and the audience. Whether or not this session is lively will depend largely on you. So without further ado let me introduce the panel. Speaking first will be George Hawkins. George Hawkins is the actuary for Plan Services. Plan Services is a member of the Dun & Bradstreet Corporation and has multiple employer contracts with over 20 carriers. George has been with Plan Services for 2½ years. Before joining Plan Services he was the group actuary of a small mutual insurance company.

MR. GEORGE HAWKINS: To give you a little idea about our size and our business, our major basis is the 2-9 lives market, as Jerry said. We have had a couple of carriers venture into higher number of lives recently. We have a couple going to 24 lives and a couple going to 49 lives. Our average case size is 4.3 lives, and that's up from about 4 lives of 6 or 8 months ago, largely because of the addition of these 15 to 50 life cases. Last month, we collected $25 million in premium - to give you some idea of our size.

Jerry has asked me to talk today on product design mainly, and I think I should try to describe some of the goals of product design. What do we want to do in product design? First, we want to market something that we'll make money on, because that's the paramount objective. We can't do that unless we market something - design a product which will sell. To make that product sell, the employer is going to have to like what we put out there, and very importantly the agents are going to have to like what we put out there. If the agents aren't comfortable with it or they

don't think it will sell - they probably won't try to sell it. So we have to try to be very attentive to their needs.

Along those lines I would say that the main thing we're looking for today in all the product designs we've seen and been associated with, is that we are in a price-sensitive market. It's very competitive out there. I once thought that in the small employer market, a small employer should really be happy to be getting some coverage somewhere because of the laws of 10 lives and up, and that sort of thing. I thought that once you get down to the small group area the competition is not going to be that tough. But, it's probably just as tough or worse than it is in the larger group market. We did a study recently on our sales and in a 3 month period in 1982 and the same 3 month period in late 1983 we noticed a trend towards the sale of higher deductibles. I'm not saying this is an innovative product design, but it's the idea that people are looking for lower cost, and we did sell significantly larger proportion of our business in the higher deductible area - something higher than $100. Now, a product innovation I've seen recently that a lot of our carriers are using, is something I call a "double deductible", and I think that it's a great little idea. We have an extra deductible for hospital admission. It's sort of a "cost containment" feature because the employee knows that if he goes into the hospital it's going to cost him an extra $100 or $200 (for example). But, in making the sale, if you include the hospital deductible, you can knock a couple of points off the rate, and make yourself a little bit more competitive. However, the employer/employee buyer does not really perceive that as a benefit reduction. If you're dealing with an underwritten block of business (which most of the blocks of business are nowadays), the people are pretty healthy and they think "I'm not going to go in the hospital", so they see that extra deductible as not really reducing the effective benefits that they are buying. The perception of the benefits that the person is getting, I think, is great too.

Let's talk about out-of-pocket maximums for a little bit. We have had a lot of suggestions to raise the out-of-pocket maximum. If you have your standard "vanilla" $100, 80/20 type plan, and you have $1,000 out-of-pocket and you want to increase that to $2,000 out-of-pocket, you can save a couple of points off the rate. However, the guy that is getting ready to buy the plan, looks at the thing and says "Well, what is the worst that could happen?". In one instance he says, "The worst that could happen is that I'll pay $1,000 out-of-pocket". In the second instance he'll say, "Well, the worst that could happen is that I'll pay $2,000 out-of-pocket". It makes more sense to him that the second plan is only half as good as the first, and he'll only be saving a couple points for it. So I don't think that's really a good thing. You have to be very careful about the perception of the benefit in the eyes of the buyer, and also the agent. The agent thinks that way too. He thinks to himself, "If you raise the out-of pocket maximum from $1,000 to $2,000, you should get 15 points off the rate". But, agents will be agents.

Another thing we've seen in trying to lower the prices is what I'll call some "unbundling of benefits". If a plan has a supplemental accident benefit in it, we've seen a couple of carriers who remove that from the plan, and offer it as an extra cost option and so it will still be there

to satisfy the agent. Funny about agents, they complain a lot when a product is not there such as the maternity benefits on a full-maternity basis or supplemental accident benefits. But, if it's offered as an option, a lot of times you see them not selling it because they're still going for that low price. We've also seen unbundling of maternity. Most of our carriers, when I came on board, were charging separately for maternity anyway. Many plans we've seen out in the market have maternity included. If you talk about pricing the maternity benefits you are going to have a little bit of a problem because of the obvious anti-selection involved. We can get into discussions on that, but if we look at the marketing aspect of the thing and one company has maternity benefits included in it's plan automatically and another carrier does not, you're going to be at a competitive disadvantage when you try to sell to an employer who doesn't want the maternity benefits. In the small employer market many of the employers (80% or more) do not buy the maternity.

Another thing that I think is coming, although we haven't seen it yet, is what I call "unbundling of the drug card". For those carriers whose trust plan has drug cards, there has been some anti-selection among carriers. If a person has a very expensive prescription, which he knows he's going to obtain every month, he's certainly going to buy that drug card. So I've seen the inclusion of the drug card plan as an automatic thing to avoid this anti-selection. The drug card deductible will probably be up from $1 to $2, to the $3, $4, $5 range. There's an excellent study by Dick Sieben, who did a study for PCS. In this study, he derived a breakeven deductible for the drug card benefit. If you raise the deductible high enough for the drug card, you could put it in the plan with no extra cost to the plan because you're not also covering prescription drugs under the plan. So I think that's a coming thing too.

Probably the biggest item in product design is cost control. Now, that is what everyone seems to be talking about. Let me distinguish between cost control and rate control. I define rate control as taking benefits out of the plan, so you can lower your rates. I recently read a brochure from a competing carrier which said "We have a very stable trust since we're only increasing the rates 15% this time, where a lot of other trusts out there are increasing their rates 20-25% for a six month period. By the way, we're also modernizing the plan. As you know, $100 is not worth the same amount today as it was several years ago, so the lowest deductible you're going to be able to have is $200." I call that rate control.

I define cost control, or cost containment features, as those which encourage insureds to seek fewer, or cheaper, medical benefits. I have to make a distinction here. In the panel discussion yesterday, some of these items were discussed and it was largely aimed towards the larger employer market. I think there was one remark made along these lines that in the larger employer market, the employer is basically paying his own cost through the experience rating or cost-plus type of arrangement. He has the incentive to tell his employees what they should do. The larger employer can have great stuffers in pay envelopes to encourage their employees to use the cost control measures. With smaller employers this is not the case - they don't pay their own claims, and

their experience is pooled. So, whatever we do in the cost control side, we have to do it on the basis that the employee will understand and seek the cheaper medical service.
I've just listed a few things that I think will work. Pay 100% for pre-admission testing, or pay 100% for outpatient surgery, to encourage outpatient surgery. But, be careful what you put on your list. Your list of procedures should include only those procedures which could be performed on either an inpatient or outpatient basis. You would lose money if you included procedures which are always performed outpatient anyway, and brain surgery would look ridiculous on your list. You have to confine your list to those things that could be done either in or out to encourage the procedure to be done on an outpatient basis.

Another plan feature which may be coming is the denial, or reduction, of claims for non-emergency hospital admissions occurring on a Friday or Saturday, unless the insured had a surgical procedure the day after admission.

Something that was discussed yesterday, and I believe is a coming thing too, is the preauthorized hospital admission. This is where the insured patient calls the clearinghouse, the administrator or the company, and says, "I have this condition and I'm going in the hospital". They authorize it, maybe give it a claim number, and say "You're authorized for six days in the hospital". If the stay goes beyond six days, there is some penalty to the insured - either a lower coinsurance or denial of benefits beyond the six days. You could even put a reward in there that if the person gets out a day or two days earlier than the norm, they could get a free transistor radio or calculator!

I'm not a big fan of second surgical opinions, but I'll just mention it here as a possibility of cost containment.

One thing I think that won't work is a wellness-type of program. Paying for an annual physical or part of one, for some over-the-counter vitamins, or for a portion of the guy's health club dues is a great idea from a marketing standpoint. However, I don't think it's going to save you money. We've seen lapse rates of 3% per month and higher in the small employer market. Dun & Bradstreet tells us that 1% of small employer businesses go out of business each month so that the lapse rate is going to be at least that. By the time you give the person all these goodies to make them healthy somebody else is going to be insuring them anyway. So, I'm not a big believer in the wellness-type of benefit.

Jerry has also asked me to say a little bit about underwriting strategies. I know Bob is going to finish up on the underwriting portion, but I'll just say that in the last couple of years we've seen a big trend towards the underwritten trust (health questions in trusts). A couple of years ago, most of the trusts we knew about were guarantee issue and then we saw health questions creep in. First, it was on the 2 life cases, then 2's and 3's, and then everything up to 5. Now, we have a lot of trusts which are underwriting through 9 lives. Even a couple, which are going up to 14 lives, are underwriting everyone. Our carriers do not use waivers or riders on individuals, nor do we go after MIB's or APS' in our underwriting. I think that's fine, but if you have a claim that comes in later and find you've been lied to on the application, I

think you have to take some action against the insured. You have to deny the claim or pay the claim and cancel coverage (if it's a small claim), or take the extreme measure of rescinding coverage. I think you need to encourage agents to get truthful answers to the health questions because it's an embarrassing situation for them too if one of their cases has to be rescinded. If you do that a couple of times, and the word gets around, I think you encourage even more truthful answers to the health questions. In that regard, we do underwrite agents for financial experience. We can look up an agent's portfolio of cases to see what the overall experience has been on that agent's cases. We can take some kind of disciplinary action on him. We can say he's not going to write any more business for our brokerage carriers. For our private label carriers (carriers that identify the field force for us), we can say "Look, this guy has sent you a lot of bad business, you ought to do something about it". We do this, but we haven't done it very often yet since you have to do it selectively because of the obvious credibility problems. If you do this a couple of times, I think that the threat has a very real effect too.

The last point that I want to make on underwriting is on renewal underwriting. It has to do with the Cumulative Anti-Selection Theory. This is the theory that says that healthy groups are more likely to lapse and get covered somewhere else, and the sick group will stay with you. The "Doomsday Prediction" you can make is that eventually the trust is going to go under because you're going to have to raise your rates to accomodate the claims on the renewing cases. This is going to make you uncompetitive, you can't sell any business, and are going to create the well known assessment spiral. There are some ways out of that, the major way being to charge renewing cases more money than the new business cases. There are several schemes which I won't get into now, but we'll probably talk about them more in the discussion part of the session.

MR. WINKELSTEIN: Thank you, George. The next speaker will be Bill Hauke. He is Vice-President of United Chambers Administrators Incorporated. Bill has been with United Chambers since 1978. Prior to joining United Chambers, Bill was Senior Vice-President of CNA in Chicago and was responsible for the total group insurance operation. I've asked Bill to talk mainly on the actuarial monitoring of the mini-group business and he will touch on both using the overall financial statement and how a model can be created of the mini-group business and how it should be used.

MR. WILLIAM HAUKE: It wasn't too long ago, that the terms MET and TPA were nasty three letter words in the group actuary's vocabulary. From the looks of the audience today, maybe conditions have changed. I'm just wondering how much of this audience represents companies that have an interest of getting <u>into</u> the small group business, and how many represent companies that are interested in getting <u>out</u> of the small group business?

When I talk about small groups, I like to talk about the 1-14 life range. There is a tremendous market out there, and I think third party administrators and multiple employers trusts are viable means of getting

to that market, developing it, and making money in it. I have not seen any definitive figures as to how big that market is (from 1-14). I have to go back to the U.S. News & World Report, published somewhere around 1980, where they talked about group insurance for small employers. I deduced that there are about 3 million employer units out there, and probably an average size of about 3 lives. We're talking about a market, just in health insurance, approaching $9 billion. This article went on to say that only about 45% of this market has been penetrated, so that leaves (if my calculations are correct) a market out there (just in health insurance) of at least $5 billion. If you went ahead and added supplemental coverages, life insurance, and AD&D, you're probably talking about a market out there of another $2-$3 billion. It is a big market and it is a worthwhile market to get into.

Let me spend a few minutes and tell you a little bit about our operations at United Chambers Administrators. I've been with them for 6 years now. Six years ago they were a self-insured trust, with all of the problems of a self-insured trust, and shortly thereafter they became fully insured and have been that way since. We're located in Lombard, Illinois, and we're technically third party administrators. We perform all of the functions of a TPA: marketing, recruiting agents, underwriting, issuing, adjusting claims, doing the billing and collection, paying commissions, and all those wonderful things. In fact the insurance company doesn't do a heck of a lot more than make a few accounting entries, and, of course, oversee the overall block of business. We do differ from normal TPA's in that we have actuarial functions. In fact, those are my functions. We do the rating, reserve analysis, claim analysis, underwriting analysis, and make all of the suggestions to the insurance company. Nine times out of ten, they go along with us. One of the good reasons for that is that we continue to make a substantial profit for the carrier. Philosophically, as a third party administrator, we are very much aware that our existence, our future, and our earnings depend on keeping our block of business financially sound. We do everything in our power to accomplish that end because we know if the carrier gets unhappy, the problems start. I think we are keeping our carrier reasonably happy. We are called United Chambers Insured Plans. By the way, the term "Chambers" refers to the fact that we market through the Chambers of Commerce. You have to be a member of a local Chamber to be eligible for our product. We're in the 1 through 14 market and theoretically we can operate in all states. However, by choice there are half a dozen states that we don't want to operate in: New York, Maryland, Wisconsin, Minnesota and a few others. It just isn't worth it to put up with the problems. We offer 5 basic plans of medical insurance and they really differ only in the deductibles and a few other little things. We sell a little bit of life insurance, and a little bit of disability insurance. In fact, 94% of our premiums are made up of health insurance premiums. You might say, "Well, you've got 25,000 customers out there, why don't you sell them something else?". We look at it this way. We only have a certain amount of talent and we don't want to dilute our talent in so many other things. In fact, one of my associates, who happens to be from the Deep South, uses the expression that "Well, we got more on our plate right now than we can properly say grace over", and that's true. We insure about 75,000 employees, and our annualized premium exceeds $90 million. More important than that is our growth rate. We have been doubling in

size over the last 2 years, and I'd like to think that we've doubled because we have superior products, rates, and marketing. However, I think that when I talk about growth, I'm including regular rate increases that have been averaging in the neighborhood of 20% over the last couple of years. Also, there's the fact that part of this market has been abandoned, by certain large carriers voluntarily and some not-so-large carriers involuntarily. In talking about the future growth of this business, I honestly don't expect that we're going to continue to double. In the first place, I think the medical care trend rate is moderating. We're seeing lower rate increases. We're seeing rate increases of longer durations. We're seeing the return of the infamous rate guarantees. Secondly, we're seeing that more trusts are coming into being and more companies are getting interested again. With the turnaround in the 1983 A&H group results, I expect to see many more companies getting back to this field. Thirdly, and I think this is important,are our own internal limitations. George mentioned rates as being a very important element of their marketplace. I think that very close to rates is "service". Even though we own our computer and our whole operation is machine-supported, our business, by design, is labor intensive. By labor intensive, I especially mean in the underwriting and in the claims adjusting areas. That's the way it is and that's the way we want to keep it. There's no substitute for that underwriting or claim curiosity. Our problem is that from a growth point of view, with the increasing volume, you do get some deterioration of service, and that is going to affect you in the marketplace.

Now, I'm going to speak about a couple of things that might be a little bit commonplace and maybe even a little elementary: our reserves and statements and things like that. There's a saying in the multiple employer trust industry, and it goes something like this, "If you think or even suspect you're in trouble, it's already too late". We know of the cases -there's a whole history of them, horror stories - necessary corrective actions, dramatic benefit changes, underwriting changes, all these things being implemented to stop the bleeding.

We all know the resulting selection spiral. By the way, when I talk about the selection spiral, there are two phases to it; one is the participant and the other is the agent. We've seen blocks of MET business that have atrophied to 30% and 40% of what they were before. I think we all realize that when you get down to 30% or 40% of what you were, rating that block of business properly is almost beyond reach.

The small group A&H business, from my point of view, requires constant actuarial monitoring. By that, I mean, at least on a monthly basis. I don't believe that if you represent a large company that you can turn a general group actuary loose once or twice a year to review the business and stay on top of it. In fact, we operate on a monthly monitoring of our business. The key to monthly monitoring is not monitoring the overall block, but to monitor it by trust and in many cases even by identifiable parts of a trust. Of course, when you talk about financial monitoring you get down to something called "incurred claim levels", something called the "incurred loss ratios", and then to something that's called "claim reserves". Now all A&H actuaries and group actuaries have their own techniques for developing claim reserves.

Who's to say which has the best method? However, determining claim reserves is not a simple job when you're dealing with a growing and dynamic block of business. One of the things I'm sure of, and I've seen this happen in large companies, is that the use of overall company reserving factors, whatever that might be, based on essentially true group, "administrative services only" plans, or what have you, are not likely to reflect the proper MET liability, or even the liability of one trust compared to another. I think that as you get into this, you'll find that each trust is different and has to be treated individually. Now, we could spend quite a bit of time talking about claim reserves. Unfortunately, very little has been written in the actuarial journals about claim reserves. Maybe someday we'll get around to writing one.

I'd like to touch on three items. The first item is incurral date conventions. We use the date service was rendered as the incurred date. We use that for all of our medical claims except for maternity and disability income. This is consistent with our contract and with our benefit provisions. But, as I think you well recognize, our reserves are terminating reserves. They approximate 2.6 to 2.7 times a monthly incurred claim dollar amount. Just in contrast, if you happen to use the convention where you keep the first date of a particular illness as an incurred claim all the way through, you produce reserves that are 30% to 40% higher. Just a little subpiece of this variation is in the dating within a particular batch of bills processed as one claim, and this could result in as much as a 5% or 6% difference in reserve levels. All of this dictates a certain amount of actuarial care in evaluating a block of MET business, especially one that some enterprising third party administrator brings to you for your evaluation in underwriting.

The second item I'd like to talk about is a reserve for extended benefits. As I told you before our reserve approach is one of a terminating reserve. For the extended benefits, our coverage for total disability beyond termination is a three month extended benefits for total disability, and we find that our cost for that is roughly about 20% to 25% of a month's incurred claims. I know that some of the products on the market have extended benefits that go to 6 months, a year, and maybe some even beyond that. It is a sizeable item and has to be considered.

The last thing that I would like to just mention is something that I call "in-house liability". That is really the inventory of what you've got in claims in-house. We inventory it weekly, and by applying dollar historical amounts, we come up with our total dollar liability. This amount does change, and when we find that this amount of inventory in-house changes from the level of inventory in our base period, we feel that we have to make adjustments in our reserves. In other words, we take the excess and treat it just like it's been paid in determining our reserve levels. Now this is a very important item, again, if you're trying to evaluate blocks of business that are brought to you by some third party administrator. You can get misleading answers if you're not conscious of those 8 to 12 boxes of claims that are stored away in the administrator's office.

The other item that I just want to talk about quickly here is a little technique, a little device, that we use and find very useful for monitoring our business, or sub-blocks of our business, or for projecting our business. I'm sure it's not original and I'm sure many of you use similar devices. We've created a model using a little Radio Shack micro computer, which reproduces our financial results as to earned premiums, incurred claims, and paid claims. The model keys off of new business written, and currently we have it going back historically for 48 months. The model includes a lot of assumptions and builds in all the rate increases over this period in time. It builds-in lapse rates, the select and ultimate morbidity, monthly claim trend factors, our own paid claim
lag pattern, and also builds in our seasonal or monthly variations in claim experience. The model can be as sophisticated as you care to make it. For example, our lapse rate (just like George said) is about 3%. However, we do know that it varies from around 4½% in the initial months to around 2% when you get beyond 4 years old. You can build that graded sort of lapse rate in. We haven't done that yet, but we will and we're continually refining the model. This model is extremely useful, especially when you're trying to monitor sub-blocks of business. Say, for example, you're looking at paid claims by state. A state with a mature block of business, that might have paid a loss ratio of 70%, might be perfectly acceptable. Whereas, another state where the business is growing at a very rapid rate with a paid loss ratio of 40% might not be acceptable. So what you've got here is a means to develop an expected loss ratio and something to match your actual against. That, at least, can turn the light on and say "Hey, something is not right here." Lastly, we find this model is extremely useful in projecting. It seems to me that we're always interested in not where we are today, but where we're going to be next year and the year after. The model gives you the opportunity to build in whatever assumptions you want as to new business, rate increases, medical prospects, cost trends -whatever. It also gives you the opportunity to project out the financial picture of earned premiums, paid claims, and incurred claims, whatever you want for the future.

MR. WINKELSTEIN: Thank you Bill. Next we will hear from Bob Carbone, who is Executive Vice-President of Consolidated Group Incorporated. As such, Bob is responsible for all non-sales operations. Bob joined Consolidated Group recently. Prior to that he was Vice-President of New England Mutual and was responsible for most of their group administrative functions, and prior to that, Bob was employed by John Hancock for several years. At John Hancock, I had the pleasure of working with Bob for several years. Bob is going to touch on the following two topics: underwriting strategies, and control strategies.

MR. ROBERT CARBONE: Good morning, I have to confess that being here puts me under something of an identity crisis. Jerry talked a little earlier about actuaries working for TPAs (which I am now). However, for the first twenty years of my career I worked for large Eastern mutual companies in which the catch word is that "the only good TPA, was a dead TPA". Hopefully, within the last ninetydays I've changed my opinion a little bit, otherwise your likely to see some blood around here somewhere.

I'd like to spend my time talking briefly on some elements of a successful underwriting strategy for the small group market. Let's start with a definition of just what a strategy is. A working definition of a strategy is that it represents a general approach intended to result in the attainment of some goal or the execution of a mission. We should start with some definition as to what the product goal is.

See Exhibit I. Depending primarily on the identity and corporate structure of the underwriting organization, small group products tend to have one or more of these types of missions. This is certainly not a complete list by any means, but the items at the top of the list (the first three) tend to be the ones that show up in corporate statements after they offically endorse the primary missions. They can be quantified to grow at a specified rate, you can make a certain level of profit, etc. Down towards
the bottom are somewhat more insidious missions, in that they are rarely taken into account adequately at the beginning of a product's life cycle, and yet they're in the back of the mind of many of the sponsoring organizations. I would say that is particularly true of the kinds of companies I used to work for. This is especially true in a large company, with it's own captive agency force, that goes into the small group business more as a concession to "keeping the rebels down" than to doing anything particularly productive.

Well, in any event, there's nothing wrong with a product having multiple missions. The definition of success is going to inevitably vary for each mission, depending upon the number of competing missions assigned to the same product. So while it's possible for a product that's attempting to execute all six of these missions to grow and be profitable, it is also likely that that product will show less growth or less profitability than a similar product which doesn't have to worry about the other things.

Why do I say that? Many national insurers, in particular, find themselves forced to compromise their pursuit of growth and/or profit in order to accommodate the marketing needs of their agency force Underwriting and claim decisions can be influenced by the relative importance to the company of the individual involved as a customer for other product lines. I doubt whether there is anybody in this room who hasn't heard the story, somewhere along the line, about the claim that had to be paid or the coverage that had to be accepted because somebody or other was a multi-million dollar ordinary life client of a loyal and highly productive company agent. Well, I'm not suggesting that this is necessarily improper, only that the financial implications of operating in this manner must be recognized in establishing expectations for the product.

Once a product's missions have been enumerated and prioritized, then it is possible to formulate an appropriate underwriting strategy. Plan sponsors interested only in growth and profit are more or less free to adopt a highly selective underwriting strategy with highly competitive rates available to those prospects that survive the selection process. A company looking more toward the other goals can't really adopt that strategy. It has to accept a broader cross section of applicants and, inevitably, a higher rate structure. The key, in any case, is the

profitable selection and acceptance of risk. The job of the underwriter is essentially to find a way to say "yes", and to do it profitably. There are few certainties in this business, but one of them is that every time a case is submitted to you and you turn it down, you have lost money. It is therefore important to prevent the case that is going to be rejected from being submitted to you in the first place, and to target your operations at accepting a high percentage of the business that is submitted. This means clear-cut, well-communicated and easily-understandable guidelines, so that your producer knows better than to waste his time, and yours, by submitting a case that's ultimately going to be rejected. Once a case is submitted, it should only be rejected if it appears probable that more money will be lost through adverse experience than has already been invested in the underwriting process up to that point. At Consolidated Group, we define this philosophy as underwriting to avoid "the bomb". We approve approximately 90% of the business submitted to us, and we have a pretty decent track record of making money for our carriers.

Along with underwriting rules and philosophies, the rating structure itself is a very important component of any plan for financial success. Most of us can recall, at some point in our actuarial studies, memorizing a list of the desirable attributes of a premium rate structure. At the top of that list were terms like adequacy, equity, competitiveness, simplicity, etc. In the small group market, these objectives are in substantial conflict.

See Exhibit II. Here, we have a list of factors that are pretty well documented as having a material impact on group medical claim levels. I think few of us would deny the relevance of any of these indicators, and yet I'm really unaware of any group medical product which explicitly reflects all of these factors in its rating structure. Well, the reason is pretty obvious. The resulting data requirements and calculation complexity would discourage most producers from even attempting to develop a quotation. Besides, as the conventional wisdom goes, it's not necessary for a pricing structure to be terribly precise. You can be a little high over here and a little low over there and it will all average out in the end.

Well, unfortunately, in the very small group business, averages don't work. Assumptions as to the makeup of the "average" group tend to break down when carrier selection is performed at units of 1, 2, and 3 lives. Particularly now, with the advent of computerized spreadsheet services, it's feasible for the producer to test the rating structures of several plans against the specific characteristics of his current client. Even if all the rate structures are okay in the aggregate, anti-selection can lead to unsatisfactory financial results.

See Exhibits III and IV. Let's look at a simple model of a typical situation. We'll concern ourselves with three small employer groups, each of which secures proposals from the same three Multiple Employer Trusts. These three Trusts have different rate structure calculation mechanisms. They may differ in their assessment of the appropriate slope of the rate structure by age. They may, or may not, recognize sex as a rating variable. They may use composite dependent rating, or they may consider the specific number and kind of dependents that each

employee has. It doesn't really matter too much what the reasons for the differences are, only that they exist. Let's also postulate that all three Trusts have rate structures which are accurate in the aggregate and which, when applied to a broad spectrum of groups, will produce the same level of total premium; $430 in the illustrated case. Let's also assume that, for each group, the average rate charged by the three Trusts is indeed the theoretically correct rate for the risk profile presented by that group. If each group bought from the Trust that had it appropriately priced, nobody would be overcharged and everybody would be profitable.

But unfortunately, we know that that's not what's likely to happen. More than likely, Group A is going to buy from Trust #2, Group B from Trust #1, and Group C from Trust #3. Now instead of generating an aggregate premum income of $430, the Trusts are only collecting in total $370, which is about 15% less than is necessary in the aggregate to support the risk. Inevitably, experience will be less favorable than had been anticipated in the pricing structures and there will be the tendency to increase rates across the board to make up for the apparent funding short-
fall. We know that's not going to work in reality and the successful product will be the one that continually refines its pricing to minimize the marketplace's opportunities to select against it. This requires sophisticated data acquisition and analysis techniques somewhere along the line of what was discussed earlier.

Well, now that we've solved all your problems with respect to underwriting strategy, let's turn our attention briefly to the problem of preventing even the most prudently selected book of business from running up medical expenses beyond the expectation of the pricing structure and beyond the willingness or ability of society to pick up the tab.

It is my opinion that until recently the benefits industry has been at best ineffective in containing the escalation of medical care costs, and more likely we have been a culpable contributor to the process. When the focus of competition among plans involves a determination of who waives the deductible for more types of expense, whose plan provides the lowest threshold for co-insurance stop loss, or whose fee limitation practices are the most liberal, it is hard to lay claim to having been on the leading edge of cost containment activities.

When we have responded to cost containment concerns, many of our actions have really been more accurately described as cost shifting. Changes in deductible and co-insurance, selective underwriting, and protective contractual provisions are all more effective at getting somebody else to pay the bill than at controlling the size of the bill in the first place.

We're finally beginning to see more prevalent utilization of such things as mandatory second surgical opinion programs, by which benefits for certain procedures are reduced if their need has not been confirmed by an independent second opinion. We are also starting to see per confinement deductibles and other forms of outpatient incentives that show some promise for influencing the manner in which medical care dollars are incurred. The industry is finally beginning to get a little bolder on

the issue of "intervening" in the delivery of medical care through such devices as pre-admission certification of benefits, restrictions on benefits payable for weekend admissions, and so on.

Unfortunately, the small group market has lagged behind the larger market in implementing these efforts. I suspect that the nature of the relationship between the small employer and his employees is partly to blame for this, as is the lack of a direct connection between claims experience under a given employer's program and his true cost of insurance. The most successful cost containment programs appear to exist where the employer takes a strong interest in influencing the behavior of his employees, and that usually happens because he recognizes the direct and immediate connection between his employees' medical expense incurrals and his corporate bottom line.

Small employers also have difficulty establishing relationships with alternative delivery systems, such as health maintenance organizations or preferred provider organizations, because they are simply not an attractive marketing target for these types of providers.

However, there are plenty of opportunities for cost containment that can be effectively pursued on behalf of the small employer by his insurance carrier or third party administrator. Education as to the medical and financial consequences of the variations in life style can be pursued by organizations of any size. In many communities, public service organizations are making wellness screening and profiling programs available at very low unit cost. I think most of us would agree that the very best approach to cost containment would be to improve the state of public health, rather than to find ways of treating the same old sicknesses more economically, or worse at someone else's expenses.

Even without requiring direct action on the part of the employer, a plan administrator is in a position to encourage cost controls, although I confess there is some philosophical dispute as to whether the devices available to the administrator represent cost containment or cost shifting. I'm talking about things like aggressive pursuit of coordination of benefit savings and restrictive fee screening levels, especially when coupled with a commitment to hold the claimant harmless from having to pay the remainder of the bill. Hospital audits are another area where an administrator can save benefit dollars for his plan, although it is somewhat questionable whether the total medical costs are at all constrained by these activities. In the long run, there are significant incentives to both carriers and employers in the small group market to pursue cost containment actively. Because of the administrative economies available to larger groups, the small employer already operates at a disadvantage with respect to the cost of his medical program, even if benefits paid are identical to those under a larger plan. As effective cost containment takes hold among the larger groups, the small employer will see this disadvantage exacerbated if he does not endorse the cost containment philosophy and seek coverage from plans similarly disposed. Plan sponsors must recognize this fact and make available increasingly the means by which a small employer who is so inclined can obtain coverage with this philosophical orientation.

MR. WINKELSTEIN: Thank you Bob. The topic of approaches to marketing compensation was not really addressed by the panel up to this point, and I'd like to take a couple of minutes to address the way that John Alden Life approaches it.

In a nutshell, what John Alden Life tries to do through its marketing compensation is to encourage the best possible field underwriting. I'll explain what that means a little later. John Alden Life uses a regional telemarketing system of selling by its sales reps to independent brokers. We have 40 or so regional offices nationwide, located in areas of highest broker density. We attempt to encourage brokers to give us their "cleaner" business, by paying them somewhat higher than the going commission rate, and offering hopefully better claims and administration (including commission-paying) service. At the same time, the rep informs the broker that if the broker tries to fool us one time with a known bad case, he will not receive a chance to fool us again. We will pull his license and he will no longer have the opportunity to earn what we consider higher than the going commission rate. Another reason we are able to pay higher commissions is because we go directly to the writing broker or agent; we don't use general agents. By going directly to the writing agent, rather than through a general agent, our rep's field underwriting is improved since he is dealing with the marketing person who is most knowledgeable about the particular case.

We also practice this concept of very strong field underwriting through our sales rep and how we pay him. In my mind, field underwriting consist of three pieces. The first piece is by our rep selecting only the brokers who give us the so-called "cream" of the business. The second concept is that we negatively sell our tough pre-existing condition exclusion clause telling the broker that if there is anything wrong with the case, he should do the case a favor and place it somewhere else, since John Alden will deny the claim when it's submitted if it is pre-existing. As a matter of fact, our reps really know their marketplace and will usually help the broker place such a case with another carrier. Usually this carrier will be known to the rep as the carrier which has the weakest acceptance criteria in the area. Lately, with a lot of companies coming into the MET business and a lot of them going to the no-loss no-gain coverage (even where they don't have to), there are a lot of carriers we can place the business with. The third piece of field underwriting is that we want the rep to provide us with good feedback on the true needed competitive premium rate in the area and how much our competitors are likely to increase their rates in the near future. This is very critical. Some of our poorer reps will give us competitive information only on the low ball competitors in the area who have a poor reputation for claims on service. This is not what I would consider "good" information. Good information is really on who a rep is losing the case to and who are their major peer competitors in the marketplace.

We pay our sales reps extremely well, and part of their pay is dependent upon the loss experience of their office. In determining the loss experience of their office, we adjust for select morbidity. A rep with a newer book of business will have a better paid or incurred loss ratio than somebody with a more aged book of business. We need to pay them a good salary, which is determined as a percent of production, since we

are compensating them to turn down business. I believe that this is an unusual concept. We want them to accept maybe only 6-8 cases out of 10 cases submitted to them. So, in effect, we are paying them more so they can afford to turn down those cases.

Okay, do we have any questions about any of the topics discussed?

MR. MARTIN HICKMAN: Jerry, I'd be interested in hearing a little more on your field compensation of your representatives. I gather that a large part of it is base salary as compared to production percentages or such. Also, what would be a range of compensation for your really top producers?

MR. WINKELSTEIN: Our really top producers can earn in excess of $150,000 a year. Of that, no more than $20,000 or $25,000 will be related to profit, but even that is a good incentive for the producers. Most of them are very profit-oriented - they always have been. They were profit-oriented before we went to a profit-oriented salary for them, since they were taking a long range view saying, "If I produce good quality business that produces a good loss ratio, then my rates next year will be lower, and I will continue to produce a lot of business and make a lot of money." But now, the connection is closer.

MR. MARK NEWTON: I guess my question is mostly addressed to Bill, but any one in this panel can feel free to answer it. What are some of the ways that your companies deal with anti-selection as it starts appearing on small group cases?

MR. HAUKE: I'm not sure I understand exactly what you mean, "as it starts appearing". We have (like most METs) a very stringent pre-existing condition clause. We had been 3-3-12 and we have just moved it up to 6-6-18. Secondly, we do underwrite up through 6 lives, and as a result of underwriting, we will either reject the individual or we will attach a waiver. I think that is different from some of the people here. We think we've been very successful in doing that.

QUESTION: If you feel you have a case or a group or an area that's in trouble do you start to selectively terminate a particular group or do you keep raising rates and hope that you'll catch up some day?

MR. HAUKE: This subject is apparently a "hot" subject in the MET business, and I think George might comment on this too because I know some of his carriers are considering what I call "durational increases". Now, we have been doing durational increases for 4 years. In other words, our durational increase kicks in on the 13th month, and it is a sizeable increase. It is an automatic increase of approximately 15%. We know that's not the ultimate solution, but at least it's a step in the right direction. Carriers that are considering durational increases have been talking about giving the policyholder the option to go back to point zero and not get the durational increase. In other words, if he is willing to subject himself to a new pre-existing or new underwriting or whatever, you don't give him the rate increase. It sounds very good, there's a lot of sizzle to that, and the agents love it. However, very frankly I think we have about 20 cases a month where people request to be re-underwritten. We also make it rather difficult for them, in that, if

they are going to be re-underwritten, we require them to produce statements from their employees stating that they understand the reapplication of the pre-existing. It doesn't happen very often.

MR. HAWKINS: I might add a couple of things to that. We have a couple of carriers who are rating on a durational basis and when you do something like this, you have to say that the first year is going to be good, because everyone has been underwritten and the pre-ex is in existence. After the first year, some of the selection starts to wear off. The good cases start to leave. You really assume that nothing bad is going to happen until at least the 2nd year and maybe the 3rd year. At that point, you can charge higher rates to certain cases or all cases who are over a certain age. Or, you can look at their claims experience, with the attending credibility problem. You almost have to look at claim files. I know of some carriers who actually look at claim files to determine which cases they want to put in certain rating pools. An idea which we haven't seen yet, or we've seen the idea but we haven't seen it used yet, is something I call a "disposable trust". Here you sell the coverage initially for a period of 2 or 3 years, and tell everyone up front that it's going to last for 3 years and then it stops. At the end of 3 years you can do something else. At that time you've lost over half of your cases that you've sold anyway (with a 3% lapse rate). If the lapse rates go up to 4% or so, you're going to have even fewer cases at the end of the 3 year period. But, at that time you just say "Okay, folks it's all over with, and if you want to come back in, that's great, and this is how you do it". You already have those cases in existence and, unlike Bill, I think you should make it easier on those cases. If you want to keep the healthy ones, you want to make it as easy as possible for them to come back to you. If you make it difficult to come back into your coverage, or to get back into lower rates, they're just as likely to go somewhere else. I think that you need to have some sort of continuation of coverage on this. You get into some sticky problems here. If you're lied to on the second application, how long is the incontestable period if there is one, and what can you do about denying that claim? However, I think that most people are honest, and you can probably just ask them health questions and go ahead and give them continuation of coverage. There are a number of different ways you can select which cases need to go into the higher rating pool. I think that's really the critical issue, you have to be able to do it accurately, selecting which cases you want to charge the higher rates, and you also have to be able to do it efficiently.

MR. CARBONE: We have thought of all the things that George and Bill have talked about, and we've all thought about the possibility of combining the resubmission of evidence with some kind of claim experience benchmark. If you can establish an experience threshold below which you will assume that the case is going to qualify for a preferred rating, then you can take some of the curse off the administrative implications of having everybody resubmit evidence every 2 years, or what have you. But, I think it's quite clear that this is one of the major problems that's going to be faced by the MET business. If we really believe that there is a turnaround generally in the level of experience, and trend rates are starting to go down, then this may be precisely the time to start implementing and experimenting with some of these approaches while the customer might be attitudinally prepared for a 10% hit every 6 months even if the experience doesn't quite justify it in the aggregate.

MR. WINKELSTEIN: I'd like to address that question also. As I mentioned earlier, John Alden Life has been in the MET business for over 14 years. So, we have gone through various anti-selection spirals already. We do almost everything that has been mentioned. We do rate our older blocks of business somewhat higher and that's pretty tricky. If you rate it too much higher, you force it into a faster rate spiral. So, that technique has to be used with a lot of judgment. Furthermore, we set up substandard pools in early 1983 as part of our February 1983 rate increase. We looked at individual claim files. When you talk about looking at individual claim files, the normal true group actuary says that a 1 or 2 life group has no credibility. Actually, by looking at the claim files, you could probably achieve a 100% credibility if you consider that credibility is how much the past experience can be used to predict the future. By looking at the actual claim file, if you have somebody who has terminal cancer, you could say with certainty that the case is going to run very poorly the following year. We divide our cases into 3 pools. One is the standard pool, one a slightly substandard, and one a very substandard pool. The rate increases were determined accordingly. The feeling was that this would be used very judiciously as a one shot clean-up to try to clean-up the really bad cases. As it was, only about 5% of our cases fell into either the very bad or the semi-bad pool. Lately, we have been operating under the assumption that if you write very few bad groups, through utilizing a strong acceptance criteria, the less will the groups written vary from good to bad. If you're writing groups that are pretty much the same level in terms of how good they are as to underwriting selection, the effects of CAST, or anti-selection theory, will hurt you less. If you lose the better cases versus the worst cases, the range will be so small that it won't hurt you as much. We've been trying to accept only the cream cases. We think that will help us in the future to avoid an extreme anti-selection spiral. This is something we have started in the past 2 or 3 years and we haven't seen the results of it yet.

MR. WILLIAM DANDY: In California, we have an extremely tough no-loss no-gain law, and, as a matter of fact, so does most of the West coast. I would suspect from some of the comments that I've heard that you gentlemen are not actively doing business in that region. My question really has been answered in one respect, but what I would like to hear from all of you is what is the threshold of guarantee issue? I understand it is up to 14 in some cases, which I applaud.

MR. HAWKINS: We've really seen it all over the place, Bill. We have at least one guarantee issue carrier now. And we have people who underwrite up through 24 lives. Probably, most are in between, but I guess the most common is guarantee issue at 6 or at 10.

MR. CARBONE: We have two primary carriers one has guarantee issue at 10, and the other at 5.

MR. WINKELSTEIN: We have guarantee issue, as such, at 5, but a lot of our reps do not use it even when they have it. What we're moving towards is having our reps obtain underwriting information on all size groups, and submitting it to the home office. But, if the case is over the guarantee issue limit and the rep says that the case is clean, we will issue it as is. In that way, we don't have the expense of underwriting a case

that probably shouldn't be underwritten. At the same time, we do have the information in our files to help us if there is a claim we are going to deny for pre-existing later on.

MR. HAUKE: In respect to no-loss no-gain; we avoid it like the plague. We are a little bit in California, but it's one of the reasons we don't go over 14 lives.

MR. WINKELSTEIN: We're in California. We have an office in San Francisco, San Diego, and a big office in Orange county. We don't offer no-loss no-gain in California. We have a trust sited in Tennessee and we simply don't have to obey no-loss no-gain in California. We do have to obey no-loss no-gain in states like Minnesota, and possibly Wisconsin, and maybe a couple of others. But, California is not an extra-territorial state as far as we know.

MR. HAUKE: Our trust situs state is Missouri.

MR. HAWKINS: Most of ours are in Illinois.

MR. CARBONE: Rhode Island.

MR. GEORGE CALAT: What about the use of pre-existing, or limited pre-existing, above the underwritten limit? If you underwrite to 6 lives, what kind of pre-existing do you have over 6 lives? Or is there any at all?

MR. HAWKINS: Our carriers have a pre-existing condition for everything we sell up to 25 lives. There's some sort of pre-existing limitation in it regardless of whether it is underwritten.

MR. HAUKE: The same with ours. We have the pre-existing on all sizes.

MR. CARBONE: As do we, with the exception that in a few states, we do have some kind of bridge provisions and no-loss no-gain provisions where they're required on out-of-state trusts in the various states. But, generally speaking, our pre-existing condition language is independent of whether or not there is evidence required.

MR. WINKELSTEIN: Yes, we have our pre-existing condition limitation on all size groups. We give a limited waiver of pre-ex in New Mexico to comply with state statute there. But, our pre-ex is 6 months treatment free - 24 months covered under the plan.

MR. MICHAEL PRESLEY: You've all said something about no-loss no-gain, but I was under the opinion that a lot of the Plan Services carriers offered that coverage. I'm sort of curious as to why you all seem to feel so strongly about that provision in small group marketing?

MR. HAWKINS: Back in the days of guarantee issue, we had some carriers who had some adverse experience because of no-loss no-gain. I think that it's a less critical thing now since most of our business is underwritten. We do offer it where we have to, of course, but we stay away from it in all other instances. There's some limited waiver of pre-ex that will pay up to a $1,000 in most instances for a pre-existing condition type of claim. But, other than that we still stay away from it.

MR. HAUKE: It's our experience that in this business, because of the very sharp select and ultimate morbidity, you're going to make your money in the first year. In the second year you may make a little bit, and then you start worrying about it. Once you go to a no-loss no-gain arrangement, or something like that, you're giving up quite a bit of that select morbidity advantage. We don't do it.

MR. CARBONE: Yes, I think that there are selection implications where the no-loss no-gain is not required of every possible alternative carrier that the employer could select. If you happen to be the guy with the most liberal no-loss no-gain, you're asking for it. I've seen it happen at insurance carriers, and it's an invitation to financial disaster.

MR. WINKELSTEIN: I have a question for the panel or for anybody in the audience that wishes to answer it. We've all talked about anti-selection and the wearing off of selection. I was wondering what kind of great strategies any of the actuaries in this room would have for turning around a really bad block of business? This is a block of business that is running a poor loss ratio. I know a lot of us have experience with a high loss ratio block of business. You put in a rate increase and the loss ratio gets worst. I'm just curious if there are any strategies anybody on the panel or in the audience could suggest, or any kind of game plan for turning around a really bad book of business?

MR. HAWKINS: I think that one thing that you can do, Jerry, is similar to what you did in '83. Not that your block of business was bad, but you can look at cases selectively to the extent that the legislators in the insurance department will allow you to do it. You can put them into some pools, and really you can run off a lot of people that way with higher rates because there are some guarantee issue trusts they can still go to. That way you'll get rid of a lot of your bad cases. Of course, for those who stay around you put on your crash helmet and just worry about what's going to hit. But, eventually the block of bad cases will get down small enough and I think you can call them a block of business and terminate them.

MR. DANDY: One of my clients, whose name I won't mention, has, in the past, issued a number of trust policies on a chronological basis, more or less. When that trust gets bad, that trust is terminated. All of the people in the trust are offered the opportunity, with appropriate underwriting, to come into a current trust. Obviously, the experience of the individual group is considered at the time an application comes in. The worst cases don't make it past underwriting.

MR. WINKELSTEIN: Our marketing personnel tell us that terminating a trust is tantamount to terminating the company. You lose credibility in the field and your marketing reputation suffers greatly.

MR. DANDY: Well, generally speaking you're not dealing with a trust that is currently selling large quantities of new business. You've gone on from your 1980 new package to a different new package that is being sold. If it's the gold trust, now you're in the platinum trust, or whatever. You terminate the gold trust because it is not producing new business; its experience is bad. People are now offered the opportunity to come into whatever current trust you're marketing. With the turnover in

brokers being as it is, many of the brokers who sold the old trust's business are writing for somebody else anyway.

MR. CHARLES LARIMER: I work for Blue Cross/Blue Shield of Illinois. What issupposed to happen to all of the unhealthy individuals at the time of the trust termination? What happens when you have a very sick person and all of a sudden the coverage is yanked, what is your response to those sorts of problems?

MR. WINKELSTEIN: I had always thought they would wind up in a Blue Cross plan!

MR. HAWKINS: Also, there are some guarantee trusts out there. Also, their plight is no worse than the plight of a participant in the uninsured trusts which have gone under, such as those involved in the Iowa State Travelers situation.

MR. CARBONE: I think that in the final analysis, the private sector, whether we're commercials, or Blues, or any combination, is going to have to come to grips with precisely that question. Big daddy up the Potomac is probably going to be the refuge of last resort, despite the fact that we have had ample demonstration that the chunk of the action that's been turned over to him hasn't turned out too well. But, I think that one of the underlying concerns of all of this is that as we all get smarter, do we all find totally effective ways of protecting ourselves from being selected by these bad groups? What the heck is going to happen to them? Something has got to happen to them, and I think that if the private sector industry doesn't come to grips with that issue in a responsible manner, we are really going to surrender an awful lot of our claim to a rightful place in this whole medical care delivery system.

MR. HAWKINS: Those people could also go work for a large employer too.

MR. WINKELSTEIN: Another technique that has been discussed in other Society of Actuaries meetings is whether you should vary your plan, or your rates, or your rate structure by geographical area. For instance, at a past meeting, a Lincoln National rep had mentioned that catastrophic claims are very prevalent in southern California, particularly those due to premature infants. You can easily have claims in excess of half a million, or a quarter of a million dollars. The Lincoln National rep suggestion was that the million dollar and the unlimited major medical maximums should not be given in southern California. You should restrict it to a quarter of a million dollars. I would like other actuaries' comments on that. I know that our Orange county rep's comment was that if you do that, we're out of business in southern California. But, I'm wondering whether particular actions like this can control a deteriorating underwriting situation in a particular geographical area.

MR. HAUKE: Being out of business in Orange county isn't all bad.

MR. WINKELSTEIN: Another thing we noticed in our experience is that we're having trouble in the Salt Lake City, Utah area. The major reason for that trouble appears when we look at our loss ratio by employee versus dependent, which we can under our computer system. Utah has the highest loss ratio of dependent claims to dependent premiums, due mainly to the

prevalence of maternity claims in that state and to the very large family sizes. We have gone to a different structure just for Utah, in that we recognize the higher family size, and so we actually have employee and dependent rates for the rest of the country, and employee and dependent rates just for Utah. I'm wondering if anybody else has similar problems in a state?

MR. HAUKE: We don't have an awful lot of business in Utah. But, you raised the question of maternity, which gets to be a very sticky problem when you're dealing with small groups. We have struggled with this and we didn't really know which way to go. We ended up 4 years ago with following Prudential's lead in their CHIP program. They provided maternity under individual policies on a fully select basis. They charged $3.75 per $100 of coverage. We follow that approach, but, of course, we didn't charge $3.75; we charged $3.50. It has worked out extremely well. The $3.50 by the way doesn't support it. It comes out that our loss ratios on the maternity (fully selective basis) runs about 85%. However, the extent of our maternity premiums are somewhere around 1% of our overall medical premiums. So it's no big deal, and we found that that approach to maternity is very satisfactory.

MR. WINKELSTEIN: Prior to February 1983, John Alden's plans included maternity as any other disability for everybody. There was no option. In February, we went to maternity being on an optional basis, in effect. The rate was extremely high, and unless the group was over 5 lives, you couldn't have maternity as any disability. You'd had to have a plan with a per maternity deductible. Overnight, our composition of new business dropped from 100% maternity to 85-90% non-maternity. We found our experience got a lot better under our new basis. One of the reasons is that maternity is so elective for this size group. Our average group size is 3.5 lives. A lot of times when you have 2 employees, maybe husband and wife, if they choose maternity you know that you're going to get hit.

MR. DAVID MITCHELL: We talked about cost shifting between carriers and different ways to do that in regards to underwriting, pricing structure, etc. We talked a little about claims administration, the hospital audits, and things like that. What, if anything, are any of you doing in the area of plan design to encourage people to choose the less expensive hospitals and less expensive doctors as one means of cost control?

MR. CARBONE: The only thing that we're doing is moving up deductible and coinsurance thresholds to allow the individual insured to participate more fully in the "rewarding financial experiences" associated with the medical care encounter. But, in terms of getting into preferred provider organizations or directed care management, we have done nothing, nor do we have any particularly bright ideas as to how you might really pull it off. I think up there at the conceptual level, several others are really persuaded that there's got to be a way to bring that device down to the very small employer. But, the practicalities of the low selection levels just keep getting in the way of implementing any of the approaches that have been tried.

MR. HAWKINS: I think you almost have to go to some outside, already-established preferred provider organization and market that as your pro-

duct. It's hard. The small employers are behind the government, the Blues, and the large employers. They stand behind a whole lot of people in their buying power for medical services. I think if we associated ourselves, it would have to be limited to certain geographical areas. But, in certain geographical areas, we could hook up with some kind of preferred provider organization and say that this is our product for the Atlanta area. But, that's the only bright idea I've thought of. I don't know of anyone that has put that into practice in the small employer market.

MR. WINKELSTEIN: I would say that 30% of our insureds are in the more rural areas of the country, outside of the major urban SMSA's. So, it would be very difficult to offer them preferred providers since they're not in a concentrated area. We pay 10% more for out-patient surgery, we limit weekend hospital admission for non-emergency, and we limit non-emergency use of the emergency room in a hospital. We have a sister company up in Boise, Idaho, Continental Life and Accident, and they have a program which lowers the coinsurance from 80/20 to either 60/40 or 70/30. The coinsurance then bumps up 10% if the person is in the hospital for a specific illness less than a specified number of days. However, beyond that, we have not made any kind of arrangement with preferred providers or H.M.O.s or even any second surgical opinion units.

MR. WINKELSTEIN: Is there any kind of rule of thumb available for how long it should take to turnaround a very poor block of business? Should a carrier expect a block of business to be turned around in a year, 2 years, etc. A corollary to that question, and this is kind of touchy, are there times when the business should be cancelled outright? Are there times when either an actuary working for a carrier, or for a TPA advising a carrier, should just say "this business is no good, and it will never get good, and it should be cancelled'?

MR. CARBONE: I don't know about the first part of your question, but in terms of there coming a doomsday for either a product or a segment of a product, I think that it's very much within the realm of the actuary or the TPA to advise the carrier to, for example, drop southern California because the experience has been so bad, and therefore the rates are so high that they're already noncompetitive and it just doesn't look that there's much in the way of realistic alternatives. Besides, those folks out there have so many alternatives to go to now, you're not going to really leave anybody in the lurch. I think that kind of advice is very appropriate. Timetables for turnaround? How much time have you got?

MR. HAWKINS: I have a couple of questions, Jerry, about marketing and sale of products. I understand that you have a 70/30 coinsurance plan and I think it's available through Continental. Could you expand on that a little bit? Also, Bob one of your companies recently raised the minimum deductible to $200 in certain areas. We have been operating with the idea that regardless of what you do for cost containment, raising the deductible is something you do to try to lower your price. Still a big big seller in your portfolio is going to be your $100, 80/20 "vanilla" plan. I'd like to hear what's happening to the sales figures on the 70/30 plan or areas where the $100 deductible plan was no longer available?

MR. WINKELSTEIN: At both Continental and John Alden we have a 70/30 plan. As a matter of fact, we have changed our basic plan in February 1984 from 80/20 of the first $2500 to 80/20 of the first $5,000. I'd say that 70%-80% of our new sales are 80/20 to $5,000. We've also added a $1,000 deductible. In certain areas of the country, we find that the $250 deductible is even out-selling the $100 deductible. I think that's mainly in southern California and in the Houston and Dallas areas. When you combine the $1,000 with 70/30 to $5,000, you get an extremely cheap rate, as you can imagine. What did surprise me is that it does sell. It sells, in fact, particularly well in the higher cost areas like Orange county, California where you could have a professional organization which largely wants to self fund their health benefits. All they need is catastrophic protection, so they buy a $1,000 deductible, 70/30 of the next $5,000 plan and look at a full family premium (under age 30) in Los Angeles of about $120. This is extremely attractive. They look at the premium and say, "Gee, I could really afford this premium, and I'm healthy, and I'm not getting sick", so they buy it. The proportion buying it? I would be surprised if over 1% of our sales are on that plan. It's good as a marketing come-on to show a really, really low rate, that does provide very valuable protection to somebody who is willing to fund the first couple of thousands of cost themselves.

MR. CARBONE: Well, with respect to that move last November to pull the $100 deductible plan from one of our carriers' portfolios, the marketing results are down. They are probably down more than the people who thought they would go down at the time they made the decision. In any event, we have decided that this is a cost containment or cost shifting move that may be slightly ahead of its time; and so we're fine-tuning it. Currently, effective May 1st, the $100 deductible plan will be back in the saddle, although with respect to both the $100 and $200 plan, we have removed the deductible waivers for accidents and a couple of the other expenses were waived. So we now will have a truly vanilla $100 deductible plan because part of the definition of "true vanilla" is that nothing gets a pass on the deductible. We've brought the $100 deductible back, but, it's not quite the same one we grew to know and love so well. We'll see what happens.

MR. HAUKE: We sell mainly the plain vanilla plan. In fact, 75% of our new business is $100 deductible business. We had an interesting little thing happen, just a couple months ago. One of our plans we felt was grossly under-rated was the $100 deductible plan. We decided to raise the rate 20% on that particular plan, and we gave the option to the group instead of taking a 20% increase to take a 10% increase and go to a $200 deductible. We were amazed that just one letter went out with the bill, and we had a 30% response of people that accepted the $200 deductible rather than the additional 10% premium increase. I don't know what that means, but, I like it.

MR. WINKELSTEIN: Bill, we had a very similar experience at our latest rate go-around. We were pushing the higher deductible to our insureds figuring that if they select a higher deductible, that will be selection for the company. We're trying to hold on to the better insureds and let the worst insureds go. It combats the anti-selection spiral by offering a very flexible plan with higher deductibles. We found we had a lot of rollovers to the higher deductibles and, in fact, a lot of the insured

who were effective prior to February 1983 on the maternity as any other disability plan wanted to drop their maternity option also. We had many insureds electing to go to lower benefits, and we think that this could only be positive for the company.

MR. CALAT: On that question of moving to less rich plans and higher deductibles or coinsurance, in North Carolina we're a low cost state and we're hearing from our sales force that there is a fair market out there for richer plans. I understand that Guardian has a low deductible, 100% pay plan. I just heard of another carrier, I can't remember the name, that pretty much offers a full service plan. Have any of you seen any movement towards these types of programs?

MR. WINKELSTEIN: We see the sales for our first dollar plan, which is 100% of the first $2500 of in-hospital benefits, geographically distributed. It is popular in Minnesota, Ohio, and in the Carolinas. We have a lot of first dollar business in North and South Carolina. We have other low cost areas which don't go for the first dollar, but the Carolinas do, possibly because of a very strong presence by the Blues.

MR. HAUKE: We had a first dollar in-hospital plan, which we finally pulled off the market about 6 months ago. It wasn't selling at all. Of course, we did have it over-priced.

MR. VAN JONES: You made a comment earlier about the large movement of people to higher deductibles and that being a favorable selection criteria. Isn't there an inherent danger there, in that, as more and more people move to higher deductibles, a selection factor has been built into the rating mechanism when we've compared a $100 deductible to plain vanilla plan with a $250 and $500 deductible? There's been a substantial credit given there in anticipation of very select business accepting those higher deductibles. When we see people accepting higher deductibles in lieu of rate increases as a defensive posture because they just can't accept the rate that is associated with the $100 plan, don't they misuse that selection criteria?

MR. WINKELSTEIN: One of the things you're implicitly touching upon is the competitive stance of your rates in the marketplace. If your rates, after figuring in your experience, are pretty much the same as everybody else's, you're okay. We review and analyze the experience of our plans with $100, $250, and $500 deductibles and our first dollar plans, individually. We find that, for whatever reason, the experience is actually better on the higher deductible plan, and we're actually charging slightly more on those plans and making up a little fat, so to speak. It seems like our positive selection on higher deductible plans, rather than being discounted more than is really needed, is being discounted less than actually shows up in the experience studies. We try to be careful on this analysis, since, as you are aware, the higher deductible plan get leveraged by inflation. So, if the cost of $100 deductible plan goes up 10%, the $500 deductible plan may go up 14% a year. We try not to overcompensate. But, we find that right now our experience more than justifies our rate differential. It could change in the future and that's why you constantly have to monitor your experience.

MR. JONES: As a follow-up to that, when you speak of deductible leveraging and rating the various deductible plans independently, do you apply

different inflation and utilization and anti-selection factors (i.e. a different trend factor) to the different deductibles?

MR. WINKELSTEIN: Yes we do. At John Alden, we have rate areas 1 through 24, and if you look at the differential between rate area 1 and rate area 24 for the $100 plan versus the $1,000 plan, the $1,000 plan is relatively much more expensive in area 24 versus area 1. Unfortunately, our sister company Continental opted for a more simplistic structure. It uses a flat deduction for the higher deductible. So it's flat across areas, so they're relatively over-charging in the lower areas and under-charging in the higher areas.

MR. CALAT: Another quick follow-up to something you said before, referring to the better experience in the higher deductible plan. I imagine that you can take duration into account there too. So, you're likely to have more new business there than you do on the low deductible plans?

MR. WINKELSTEIN: Yes, we do.

MS. JUDY DISCENZA: Jerry, I told you a while ago what we do when we find a book of business that looks like it's been in trouble. I think that the panel has given some good examples in the last couple of minutes, and that is to find out where you screwed up either in pricing or your product and try to correct that. What I'm wondering is if any of you have or have seen companies that, if we go back to that southern California example, feel that within a specific area they're in so much trouble that they are on the verge of cancelling. Has anyone gone to the point of seriously eliminating plan benefits, to turn it into basically a catastrophic coverage rather than cancelling the book?

MR. WINKELSTEIN: To me the major dividing line between when you try to save a block of business or get rid of it, whether in a particular area or plan or whatever, is when your past experience forces you to charge rates which are extremely out of line with the marketplace. For example, if everybody else in the market is charging a family rate of $120, and your experience says you have to charge $180. Unless you can further segment that marketplace, you almost have to pull out of it, or make the conscious decision to take future losses for a period of years until it turns around. We have thought, in the past, that if a situation did deteriorate to a very bad level we might force current and new business to go to a $250 or $500 deductible. We have hesitated to take that step in the past, because the marketplace may perceive it as cancelling a block of business, and that has a lot of implications beyond just that particular geographical area. However, that is something we would consider doing. From the comments I hear, maybe John Alden is one of the few companies that does well in Orange county. Our San Diego office and our Orange county office, and in fact our San Bruno office, which is our San Francisco office, are 3 of our better loss ratio offices. I think that is mainly due to the quality of the sales reps in those offices. We also have a Los Angeles office that isn't doing so well.

MS. DISCENZA: Out of curiosity, how does your Miami office do?

MR. WINKELSTEIN: As a matter of fact, our Miami office is doing fairly poorly. But, when we look at our experience by county our experience in

Dade county is not that bad, it's our experience in Monroe, Palm Beach, and Broward, which are the surrounding counties, which is very bad. Although I would not like to admit it, possibly a major reason we have done so poorly is more of an actuarial error than a marketing error. That is, what the former group actuary did was to look at the experience, prior to us going on our new mini-group computer system, using accounting records, and this is where danger can come into an actuarial analysis. He was looking at experience by sales office. For instance, we have a Houston sales office, a Dallas sales office, and a Miami sales office. He kept looking at the Miami sales office experience, and it was bad. So he kept raising the rates in Dade county, which is where Miami is located, by 20% every 6 months and the experience would keep getting worse. This is because,unbeknownst to him, the marketing rep went out to Key West, in Monroe county, and up to Palm Beach county and he was selling like crazy in those under-rated areas. But, the experience he was looking at continued to look bad in Miami. So, in effect, Miami is not doing well, but it's not due to the Miami area itself.

MR. DANDY: On rate structures, my companies, at least, are almost entirely using separate male and female rates on employees. Some have broken out children rates, in addition to husband and wife rates too. What are you doing in that respect? This may be a moot question with the Unisex Bill, but how do you anticipate that if you are using separate rates currently that you will react to unisex?

MR. HAWKINS: Bill, most of our companies use male and female rates; something like 85-90% of them use male and female rates. Most of them use, what we call, a "full dependent split" having a single, a two person rate (two person meaning spouse), and children only rates, as well as a full family rate. We have been going to that full dependent split over the last couple of years,and interestingly, I don't think it's made a big difference in our block of business and the mix of business we're getting. My opinion on the unisex thing is that even if it passes, it's probably not going to apply to small employers anyway. Maybe - maybe not. As we heard the other day, it may not apply to group-type coverages at all, and I think we should just sit back and wait for the marketplace to tell us. Most of our carriers will probably sit back and wait for the market to tell them that they have to go to unisex rates.

MR. HAUKE: We are not on sex rates. We are strictly on unisex employee. On dependents, we do, for the most part, break the rates down between employee, employee and spouse, employee and child, and an employee and 2+ children family rates.

MR. CARBONE: Both of our carriers are on unisex and they do not break out dependent units. They have an employee rate and a family rate, at each age, and that's as far as it goes. So far the experience has been good. But, in view of some of the things we talked about a little bit earlier, you've got to be concerned about it.

MR. WINKELSTEIN: When I joined John Alden 2½ years ago, they were on an employee rate and a composite dependent rate without sex distinctions. Since February 1983, I put them on a male adult, female adult, and children basis so you could mix and match. What that does in addition to

putting the proper sex on the spouse or single employee, it also puts the proper age on the spouse. So if you have a male employee age 50 with a female spouse age 28, who is in her prime maternity years, we would pick up a maternity rate for her. On the other hand, a lot of our competitors would just base the dependent rate on the employee age. So we try to be as exact as possible. After putting in our sex distinct rates and our "tiered" dependent rates, we found that our distribution of business did change and we are writing many more cases with spouse only and children only coverage. This is particularly true in southern California where there are a lot of female employee and children coverage. We follow unisex regulation and my preference is that I hope it isn't passed. If it does pass, we would be forced to obey it. But, my feeling is that, in the meantime, we are probably rating more accurately than our competitors who are jumping the gun and going earlier.

EXHIBIT I

PRODUCT MISSION

- To grow
- To make a profit
- To generate income for field force
- To be a full service company
- To gain access to new customers for other lines
- To protect current customers from having to look elsewhere

EXHIBIT II

Factors:

- Location
- Industry/Occupation
- Prior Coverage/Experience
- Age
- Sex
- Income
- Dependents
- Lifestyle - smoking, drinking, exercise

EXHIBIT III

RATE MANUAL ANTI-SELECTION

-Proposals-

	MET 1	2	3	Avg.
Group A	100	80	120	100
Group B	130	170	150	150
Group C	200	180	160	180
Total	430	430	430	430

EXHIBIT IV

RATE MANUAL ANTI-SELECTION

-Sales-

	MET 1	2	3	Avg.
Group A		80		80
Group B	130			130
Group C			160	160
Total	130	80	160	370