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MEDICAL COVERAGE FOR GROUPS OF TWO TO FOURTEEN

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Recorder: ALEX ZEID

- Selective underwriting standards
- Renewable options
- Producer controls
- Compliance with state laws and regulations
- Control and profitability

MR. HOWARD J. BOLNICK: I'm president of Celtic Life Insurance Company. Celtic is a medium-sized company that derives most of its income from a small group product called the Horizon. The Horizon is an underwritten product using a short-form, nonmedical questionnaire. We don't require medical information bureaus (MIBs) or attending physicians' statements (APSs). We write from one to twenty-five lives but absolutely *no guarantee issue.*

This competitive product is sold basically in the brokerage market. We have some arrangements with major eastern companies to distribute our product through their field force.

We have "tiered rating" or, more precisely, "durational rating," where the rates change by the age of the group. We use a third party administrator, Plan Services of Tampa, Florida, exclusively. The product design of the Horizon has a range of plans but nothing fancy or unusual. Our cost-containment ideas and features are relatively limited. The product has been profitable for the five-year duration of the program. From all indications it will continue to be profitable. For compliance, we have an Illinois trust. We filed for informational purposes in all the other states we write business in, which is every place but New York.

MR. ROBERT F. CARBONE: I represent Consolidated Group, Inc., a mass marketing third party administrator that's celebrating it's fourteenth birthday today. We offer between eight and ten products, depending on how you count the variations, in the multiple employer

trust (MET) and association markets. They are underwritten by seven quality carriers. We cover groups of one to ninety-nine lives on the MET side. On the association side, we cover one life to the number of lives in any size organization which cares to join one of our associations. However, the principal thrust of our activity is in the one to fourteen lives. We medically underwrite virtually all of our product under ten lives. The guarantee issue threshold is five lives in selected states for certain products. It also depends on the degree of protection that we're able to rely on because of preexisting conditions.

We do not have formal tiered rating or durational rating with pricing approaches. We are starting to develop a de facto tiered structure with one of our products because we recently reduced our new business rates. This puts us in the position of having a rate structure in some areas lower than our renewal rates. We perform all the administration functions, including marketing and underwriting issue, except paying claims. Our carriers pay the claims. Our plan design is main-stream, main-street approach. We want an attractive product not only for a large number of employers but also for a large number of independent agents and brokers who constitute our primary distribution system. We have a network of salaried field representatives. Their jobs are to promote the product with the agents and brokers to provide technical support and assistance. We also have a number of general agency arrangements across the country and use telemarketing. Our telemarketers deal directly with the association member employer on the association business.

Every product we have is on a cumulative basis from the date of inception. In the last two years every product has made money. All our METs are Rhode Island situs, and for the most part we defer specific compliance activities to the carriers.

MR. JEROME WINKELSTEIN: My first perspective is from my current employer, Blue Cross/Blue Shield of South Carolina. My second perspective is from my employment at John Alden Life Insurance Company. My third perspective relates to my consulting experience with several small insurers and third party administrators (TPAs). Blue Cross/Blue Shield does not utilize a trust but writes each group as an individual group case. It requires a short-form medical on two to six lives and employs preexisting-condition limitations for groups up to twelve lives. It will issue groups with thirteen or more lives on a no-loss/no-gain agreement. John Alden wrote through a trust, and it requires both APSs and MIBs. It performs a significant amount of up-front underwriting. It has short-form medical questionnaires for one to five lives. Everything from six or more lives does not require a medical, but the preexisting conditions are always in force. Certain states require some deviation from requirements.

The other companies I've been involved with wrote through a trust. The amount of underwriting varied. Some had a variety of short-form medical questionnaires and underwrote all size cases. Others had no short-form medical and really depended upon preexisting exclusion to control the claims.

John Alden markets using a controlled telemarketing set-up through company reps to personally producing general agents. The other companies, including Blue Cross/Blue Shield, went through the master general agent route.

John Alden also used a substandard pool approach in durational rating. This was a one-shot deal instituted in February 1983. Under this approach, John Alden reunderwrote individual groups based on what the prospective morbidity experience would be and gave individual rate increases. John Alden has also gone to durational rating, whereby new groups are on rate levels as of 1983. The other companies I've been involved with are not using durational rating as such. However, they are continually closing down trusts and starting new trusts, which is effectively the same thing. All the companies I've been associated with, except for my former TPA clients, administer the business themselves and do not use the services of third party administrators.

The medical benefits sold by carrier, other than John Alden and Blue Cross/Blue Shield, have been very standard. John Alden had a standard package except that it had a flexible choice of deductible at the employee level. Blue Cross/Blue Shield's plan of benefits for the under-fifty life market is a preferred provider organization (PPO) plan with many cost-containment features - the only plan it sells. It has approximately 25 percent of the physicians in South Carolina participating as part of its PPO plan.

John Alden has never been worse than break even on a GAAP basis since it entered the mini-group field back in 1970. Blue Cross/Blue Shield was very profitable in 1984 in its community-rated block of business, which is defined as its under-fifty lives. The other carriers I've been associated with have had mixed results.

Blue Cross/Blue Shield only has to comply with the laws of South Carolina. It currently does not have a trust product, so it writes normal employer/employee groups. John Alden has its trust sited in Tennessee and it writes in most U.S. states with the exception of New York and a few others. Some of the other carriers were local, particularly in the Texas/California areas. Others were more widespread geographically.

MR. BOLNICK: Mr. Carbone, is there any significant difference in claims experience by type of producer?

MR. CARBONE: We haven't seen it. We market primarily using a broker. In some areas we work through a salaried field rep, and in other areas through a general agent arrangement, we also use direct telemarketing for the association side. To the extent that we've been able to break experience down into credible data cells, we have not found any significant difference in experience levels that can be attributed to differences in the marketing approach. In addition to marketing differences, product, structural design, and geographic differences cloud the issue and largely account for any differences in experience.

MR. BOLNICK: Mr. Winkelstein, have you seen any differences in claims experience by producer?

MR. WINKELSTEIN: There are significant differences. John Alden got into the issue of field underwriting very heavily. Although field underwriting is one of the most difficult types of underwriting to put in force, it also can yield the best benefits. John Alden markets use commissioned reps who are employees of John Alden. They performed various degrees of field underwriting. When a particularly good field-underwriting rep left to be promoted to a bigger office and was replaced by a rep of more average quality, the experience was directly reflected and worsened. When we eliminated the poor proponents at field underwriting, other reps came in and did a much better job. Furthermore, a rep was responsible for a particular geographical area, so at times it was difficult to differentiate between a geographical area variation in the experience and a variation due to good field underwriting by the rep. This type of marketing arrangement produces better field underwriting but is more expensive. It costs more money to have a highly trained person handling the phones rather than a college grad that some TPAs are using.

MR. BOLNICK: Mr. Winkelstein, what does the field rep do in the underwriting? Is he just underwriting group characteristics or looking for health information? What is he trained to do?

MR. WINKELSTEIN: He is trained to do both and, furthermore, he would underwrite the PPGA. The commissioned field rep is concerned about the quality of his business because the more business he produces the more money he makes. Many reps were with John Alden five, six, and ten years.

The reps also underwrite the actual brokers or develop a culled list of brokers. They also make sure that all submitted applications are complete. They question the broker about the case and sometimes hear something significant. The broker may ask the rep about preexisting exclusion or whether a certain medical procedure is covered. The rep then follows that further and finds out if there is a problem. The rep might suggest that the broker place the case with another insurer until the problem was resolved and then bring it back to John Alden.

MR. BOLNICK: Mr. Carbone, after hearing Mr. Winkelstein's story of how to motivate and involve the field people with underwriting, does it surprise you that you don't see more differences by producer in your system?

MR. CARBONE: We do not have the kind of field underwriting expectations or authorities among our salaried people. We centralize our underwriting activity. It all takes place in the same place under essentially the same sets of standards. Therefore, the financial experience is usually consistent. New England Life developed a small group product and separated experience by type of producer: the company agent and the outside broker. It further separated its experience by producer within an agency so that it had the benefit

of a laboratory experiment with the same plan marketed in the same geographic territory underwritten by the same underwriting department. The only differential was the agency or the producer delivering it.

There were individual situations in multiple agency cities where the business of one agency was considerably better than the experience of another agency in the same city, but I can't make a general statement about the experience of different classes of producers.

MR. WILLIAM HAUKE: Isn't there a big difference in the guarantee issue versus the individual underwriting business?

MR. CARBONE: We have not seen a difference in our experience levels between our guaranteed issue and our medically underwritten product. We are very selective about the geographic territory in which we will guarantee issue, only where state regulation is such that we feel we can have substantial protection against preexisting conditions. The business is of such persistency that the front-end preexisting protections in the products we offer seem to have filtered out the antiselection. Since we don't see any substantial difference in experience between the medically underwritten and the nonmedically underwritten blocks of business, it's tough to discount it in more detail than that.

MR. EDWARD O'NEIL: Since the change in rate associated with writing a poor block of business will not be reflected for eighteen or nineteen months, is there any gain or loss used in the compensation formula based upon financial results in a given year in order to incite them to write an appropriate block of business?

MR. WINKELSTEIN: We were moving in that direction prior to my leaving John Alden. The three marketing vice presidents of the three geographically distinct crews were on an experience-incentive bonus based on their own region. The senior vice presidents above them were also on a loss-ratio incentive. We had revised the marketing compensation formula at the macro level and wanted to get down to the micro level - the individual rep or the individual office. The danger of coming down to the individual reps is that they may steal the best business from each other so we were willing to go on an office basis. There were complications doing that. If we had a good rep in the Memphis office and a slot in the Houston office would open, the rep from Memphis would be moved there. Moving reps among offices made tracking experience more difficult.

MR. IRWIN STRICKER: We have our group field reps as our separate marketing arm. Our experience shows that the business we get from both our individual field force and from brokers is not dissimilar. Experience differs from producers when you would make underwriting deviations.

MR. WINKELSTEIN: We had this other layer of selection that was further analyzing and field underwriting the business to encourage brokers to submit the type of business we wanted.

MR. BOLNICK: The screening system a company uses attracts a subset of all agents. There are good agents and bad ones. Good agents can tell good business from bad business. Bad agents can give you bad business. A company has to structure its agents' screening system, either in the home office or in the field, to screen out those agents you want producing for you. If you aren't successful, you will get the bad agents and bad business.

Mr. Carbone and Mr. Winkelstein, how sensitive is a small-group health insurance package to price?

MR. CARBONE: It is more price-sensitive than it used to be because the mainstream products serving the small-group market have not developed or been perceived as much more than a commodity. There are specialty products on the market that do not attempt to broadcast themselves across the mainstream. We don't happen to market those products.

MR. WINKELSTEIN: I think Mini-group is a very price-sensitive product. The consumers, or at least the agents, are becoming more aware of the stability or the so-called Best rating of the company. The name and stability of the company mean a lot, although price is still the motivating issue for brokers. Commissions are a motivating factor for agents.

MR. BOLNICK: Larger companies question whether they want to be in the small group business with their own product because they feel they have a controlled field force. Most of the people we call brokers are agents of other companies. Many of these companies have products with premiums that are 10, 15 and 20 percent higher than ours. Their agents are writing business with us and not their own companies. So even within that so-called controlled market, there is a good deal of price sensitivity or commission sensitivity.

Would Mr. Carbone and Mr. Winkelstein share their short list of two or three things that most upset producers in the small group area?

MR. CARBONE: Producers are most aggravated by processing delays, inconsistent underwriting, and inadequate notice of changes affecting their clients.

Inconsistency is probably the number one aggravator of producers. They need to build a sense for the character of the product; that is, this product will let you do this, this product won't let you do that.

A producer doesn't like inadequate notice which includes finding out that you are communicating directly with his client on a matter of substantial impact without prior notice to the producer. A company needs then to be an ally in presenting the changes to the customer.

MR. WINKELSTEIN: The number one item that tends to make agents leave the insurer is a service/computer problem, primarily not paying commissions on time. John Alden went to a new computer system in 1982-83. Various bills were mishandled, and lapse notices were sent

out, resulting in its not paying agents' commissions on time. If you don't pay commissions on time, the agent community figures you're running out of money. The second most upsetting item is other service/computer type problems. The third item is rate increases. Your lapse rate peaks around that time even if the rates are still competitive after the rate increase. It is always better for a company to present a consistent picture of rate actions, going up 10 percent every six months.

MR. BOLNICK: What are the trends in the small group product market?

MR. CARBONE: The small group is lagging behind the larger group in terms of the things that become predominant. The small market, two to fourteen lives, is now including dental insurance and other maternity. Cost-containment through plan provisions rather than through interventionist claim management techniques is increasing.

MR. WINKELSTEIN: Many insurers are realizing that it is extremely difficult to price optional maternity if the group is too small. Even though there are still a few companies selling optional maternity to one or two life groups, they are offering a suicidal product because of the maternity claims themselves and the preemie claims. Even under nonmaternity coverages, you have to pay for a premature birth. But if you give an insured who is going to have a child shortly to another insurer, then you don't have the maternity claims or the preemie claims. Another development is a trend toward higher deductible and higher coinsurance ceilings. There is also a trend mainly through the planned-services companies to what is called the "split deductible" or separate deductible on hospital only and on other than hospital.

MR. BOLNICK: Recently, the Health Insurance Association of America (HIAA) published a survey on plan design that was structured by size of group. The survey agrees that the small group area lags behind the larger sized groups in adopting new approaches to plan design. This confirms that standard products are fine in the small group market.

MR. WINKELSTEIN: Many trusts and smaller insurers don't use durational and tiered rating but close up old trusts and start writing new business into trusts at lower rates. Sometimes, some of the business in the older trusts would be reunderwritten into newer trusts. The older trust would be terminated eventually when it became too unprofitable because of the antiselection process. We performed a substandard pooling study. We screened out the groups we wanted to study by looking at paid loss ratios. These groups were investigated further by digging into the claim files with the claims examiners to decide which of these high loss ratio groups were predicted to have their high loss ratios continue into the future. Groups which had an insured with cancer claims or some other chronic illness were put into one of two levels of substandard pools. One was given a 30 percent surcharge, the other a 100 percent surcharge. We didn't want to go over 100 percent because of possible unfavorable marketplace or

legislative pressure. The substandard pooling project demonstrated that the cases put into the substandard pool amounted to about 5 percent of our business premium-wise and produced 25 percent of our claims. That would be expected to continue.

MR. BOLNICK: We start with the premise that a block of small group business written today inevitably gets worse with time because selection wears off. When you have a large number of small groups in a block, there is a tendency for the better groups to leave with time. They feel more comfortable moving from company to company.

We have chosen to durationally rate the business. That is, as business ages, rates increase over the new business rates. At a select point in time, though, we give the groups an opportunity to reenter. If the group provides us with new evidence of insurability, it reverts to the new business rate. This forces a selection between bad business and good business. We keep the healthy groups that otherwise would leave and we isolate and concentrate our resources on watching the bad business. Bad business is isolated from the rest of the business, so we can take renewal action on it as needed.

MR. CARBONE: We have some concerns which have prevented us from implementing any specific tier program, such as how far do you push it? How far do you let new business and renewal rates get apart? Do you allow the durational tiers to follow their experiences, which sooner or later will lead to termination of business? We're concerned about a consumerist backlash based on a perception of bait and switch - business will be brought in at a low rate level and when it doesn't go anywhere else, the rates go up.

An administrator's perception of acquisition costs associated with new business is that the profitability profile is very different from the profitability profile of a carrier, who is either just bearing the claim risk or doing the entire product. The administrator loses money in the first year and starts making it back in the renewal year. The carrier, in regard to claims, has precisely the opposite pattern. As years pass, the curve goes up. We have to be very careful in our organizational and administrative role to give due recognition to the impact on both carrier and administrative profitability of any durational rating structure. Under a tier rating structure, it seems inevitable that you will get substantial interest from many of your customers and producers to reapply for reentry whether or not it is an approved time. This may cause a second round of acquisition cost for the piece of business you already have on the books. A major reason for the favorable claims experience of new business is the value of contractual limitations on preexisting conditions. If you're going to reunderwrite an old group, you have to deal with starting a new preexisting period and protect yourself contractually from its consequences. This is in addition to the value of underwriting selection.

MR. ROBERT COLLETT: Mr. Carbone, are there additional acquisition costs with reentry with field compensation or are you talking about just the administrator's costs?

MR. CARBONE: I was thinking of the administrator's costs depending on what your field compensation arrangement is. If the commission compensation structure pays higher in the first year, there are higher costs. Our field compensation agreements are level scales which don't cause that problem.

MR. BRIAN HIRST: You spent a lot of time identifying those 5 or 10 percent that you think are the bad risks. Have you theorized about how you would identify the 5 or 10 percent that are the exceptionally good risks perhaps allowing the lower rates than your new business costs? Secondly, on your tiered approach are you seeing any kind of broker backlash?

MR. BOLNICK: You are going to get yourself in trouble with agents if you don't explain tiered rating up front. We learned over the years to make better materials available to the agent, so that he knows the rules of the game at the outset.

Regardless of whether you've made the agents aware of the rules, some always think that adverse actions are not going to happen to them. When it does happen, you inevitably have problems. But if you've explained tiered rating to the agents in the beginning and periodically remind them of what you told them, you reduce the problem.

MR. WINKELSTEIN: In regard to super select groups, John Alden studies demonstrated that if the group wasn't bad it was probably very good. If you look at a scatter diagram of loss ratios, most groups have a zero percent loss ratio. Here we are talking about a group with an average size of three to five lives. Even though in our substandard pooling study, we wound up with 57 percent of the groups, 35 percent of the groups initially came through the first loss ratio screen. Of these groups, approximately 30 percent had high loss ratios due to either maternity claims, hysterectomies, or other conditions which weren't likely to continue. These groups were probably no worse prospectively than groups with a zero percent loss ratio.

We saw very geographically differentiated broker backlash. A broker in Kentucky didn't want us to single out two of his twenty groups. He requested that we give all of his groups slightly higher rates so he wouldn't have to go back to one insured group and tell them their insurance is going way up because of one claim. In areas like Houston, Texas; Southern California; and also Southern Florida, where there are so many companies with no loss/no gain coverage, the brokers loved the substandard pooling program because their new business rates were approximately 5 to 10 percent lower. They had a more salable product, and the premium they lost on the two substandard groups would be more than replaced by new business written due to more competitive rates. They also had no trouble placing the substandard groups' business with another carrier.

MR. DONALD M. PETERSON: We don't write groups below ten lives but are considering it. Do you have a general maximum out-of-pocket expense for the certificate holder? On the tiered rating do you have some sort of pooling mechanism across the area so that one particular

tier or pool within a tier would not, in effect, be going bankrupt?

MR. WINKELSTEIN: The pooling mechanism didn't really make sense for John Alden because if a person had a continuing cancer claim, it was going to be a big claim. We wanted to surcharge that person or group with the hope that he would leave and go to a no loss/no gain carrier and get his claim paid by somebody else in the future years. The standard out-of-pocket maximum in many groups seems to be somewhere between five hundred dollars and one thousand dollars, including the deductible and coinsurance. Also a million dollar maximum is standard.

MR. RICHARD HELMS: We have a series of experience pools at 5 percent intervals and give credit to both the good and bad risks. A given case will move up or down one pool at a time at each renewal. We keep more of the good cases and lose more of the bad cases.

MS. JOAN HERMAN: Mr. Bolnick, how do you explain your reentry points to a group?

MR. BOLNICK: We trigger the reentry point by sending out special materials to groups. Reentry at uncontrolled points raises serious questions. If reentry is at our request, the group has a no loss/no gain contract. Coverage has to be identical before and after the reentry point. However, we don't want groups "gaming" the system prior to our reentry offer, so we charge a sufficiently unattractive penalty for reentry before our offer.

MS. HERMAN: Have you gotten to enough of the reentry points to have some idea of what percent of the groups reenter?

MR. BOLNICK: It appears that a healthy percentage of the groups reenter. For those that don't reenter, a healthy percentage terminate. The system works so that the bad groups go and the good groups stay.

MR. STEVEN GWIN: Does the preexisting condition reapply when the groups are reunderwritten?

MR. BOLNICK: If we are the ones that trigger the reentry, the coverage must be the same before and after the reentry takes place. This means to me that you must have no loss/no gain treatment.

MR. MARTIN STAEHLIN: How do you decide which parameters you're going to use to identify the groups you want to keep? You talked about tiered rating, 5 percent pooling intervals, and superselect. Renewal business makes your profits. At least you know those groups and want to renew certain proportions of them. How do you decide when? We want to switch to tiered rating or producer loads to guarantee that we'll get a higher proportion of renewal business. Is that totally in the actuarial sphere? Is it in a profit center concept, a marriage of the marketing and actuarial people, or just deciding how to find these good groups?

MR. BOLNICK: Do you use some sort of demographic criteria such as loss ratios, agents, ages, and durational age? Do you discriminate

among groups by looking at each individual within a group? Both types of systems have been used.

MR. WINKELSTEIN: You have to sit down and look through the group because a bad loss ratio one year does not have any credibility in predicting that group's experience the next year. I think you have to dig into the claim files with the claims people and effectively turn a one life group into a 100 percent credible group. If you know that one person in the group has a continuing claim, the claim will continue.

John Alden did durational rating in which our new business rates were slightly lower than our renewal business rates because of a new benefit package with a higher coinsurance ceiling which was underrated relative to the old plan. This causes the existing group to self-select for the insurer. When a group did go to the new business rates, we reapplied preexisting conditions.

MR. STAEHLIN: Have you measured how much cost is associated with group-by-group growth?

MR. WINKELSTEIN: The review of each file is extremely time-consuming. Substandard pooling was a one-shot deal, and it took about a month and a half of my time plus similar amounts of time from the claims examiners. Therefore, you can see that it's extremely expensive, although worthwhile. The effect of these substandard pool rate actions produced an equivalent of a 5 to 10 percent premium rate income hitting only 5 percent of the business, allowing us to raise our overall rates 5 to 10 percent less.

MR. BOLNICK: Point of sale options can use the computer more effectively than when undoing a ten-year accumulation of a business problem. You make critical information stored in the machine available when needed and use plan administrative procedures to get additional information from each group. A tiering rating program can be designed that doesn't require someone to look at each and every claim and still be quite effective. However, you need detailed information by group. If you want to use only demographic information, you will have the same problems as you would in underwriting small groups by guarantee issue criteria rather than by using medical information. Medical information is always more effective.

MR. CARBONE: What kind of a reception does a renewal pricing approach which drives itself to a large degree off the claim experience of individual groups get from the producers and the groups? Do you get criticized for indulging in experience rating in a product that's sold as a pooled product? Do you get criticized for treating a widely perceived individual medical product as a big group?

MR. WINKELSTEIN: The groups that got placed in the substandard pools hated it. There was a mixed reaction from the producers. They were told that our new business rates were lower because of what we were doing to a small piece of our business. The result was that the rates needed for the larger portion of business were also lower.

The reaction from legislators was also mixed. We had several negative comments in Minnesota. We were injecting another parameter into a definition of a homogenous group. In the past, we looked at the age, sex, dependence status, and geographical area. Now, we are also looking at the prospective claim experience, not unlike what personal-line casualty insurers do. The legislators that questioned us were satisfied with the explanation. It was a one-shot cleanup of a trust that had been rocking along with all the cumulative effects of antiselection of over thirteen years.

MR. THOMAS HANDLEY: Did you have a predetermined number of tiers to use under your tiered rating approach? Did you let the experience drive it? If so, when you set the rates for a different tier, did you look at the experience or just estimate a 30 percent increase overall that would maintain the 10 percent differences?

MR. BOLNICK: Our driving force was fear. When we implemented the program, we didn't have any aged business. We are working hard to get information on an ongoing basis about what our "aging curve" looks like. In lieu of this information, we estimated what we thought the tier structure ought to look like. Now we are in the process of reevaluation based on fact. Even today with five years of historical experience, we can't tell exactly what the aging curve looks like for more than a limited duration.

MR. PETERSON: If in the epitome of tier rating we isolate all the bad groups and avoid writing them, where are they going to get their insurance from, and what are we doing to ourselves as the insurance industry?

MR. BOLNICK: We are balancing the solvency of companies against public needs. Tiered rating does not provide a perfect solution. State pools for substandard risks are a source for some of the people who can't find coverage in the commercial marketplace. I don't mind paying some money to have these pools run by the state so that bad risks are spread uniformly among companies participating in the market.

MR. CARBONE: As a private insurance industry, we should all make it our business not to exclude from coverage any significant section of the population. That creates a vacuum which invites a solution which is likely to be much more widespread than merely solving the problem at hand. I agree with the desirability of assigned risk pools; but I would rather see it done privately, possibly through a reinsurance network, or something that the industry would establish.

MR. WINKELSTEIN: The way to handle this is through an uninsurable pool run by the state. I'd rather have some of our competitors also share in these risks, so the state pool concept is much more desirable.

MR. BOLNICK: Many substandard risks have been covered by guaranteed funds. The guaranteed issue versus the simplified issue or nonmedical underwriting is an important topic. Is there a group size below which guarantee issue doesn't work? Is there a practical upper

limit on the size of group for which any kind of health underwriting can work?

MR. CARBONE: Theoretically you could build either a medically underwritten or guaranteed issue product that would work with almost any size. Practically, five lives seems to be about the place where competitor practice is drawing the line between guaranteed issue and medical underwriting. The guaranteed issue product can work if it is structured to take maximum advantage of preexisting condition limitations. In theory you can medically underwrite as high as you can get people to submit evidence. However, you have to build some flexibility into your medical underwriting structure. Once you get past the point of four or five lives, you are multiplying the probability tremendously that somebody in that group is bound to have a problem. It is virtually impossible to medically underwrite more than five or six lives unless you are willing to underwrite a case level morbidity screen which may allow a marginally insurable or maybe an outright uninsurable to qualify for coverage as part of a group which in the aggregate is acceptable.

MR. WINKELSTEIN: There is no lower limit below which guaranteed issue will not work at John Alden. Certain offices, because of state regulation, were not allowed to use a preexisting condition exclusion or had to give no loss/no gain to a group that had prior coverage. Those offices had relatively good experience, while other offices, where we give guaranteed issue because of competitive pressure, did very poorly. Field underwriting will help you guarantee issue at a lower level. You do not want to be the insurer, however, with the weakest acceptance criterion in any area since you would then tend to become the dumping ground for all the bad groups that don't qualify at any other company.

There is no upper limit from an underwriting standpoint on the size that guaranteed issue is effective. If you can get medical questions answered on a thousand life group, it would be better than not. However, ten may be the maximum competitively because there are simply not that many companies that require short form medicals above ten. Brokers tend to place business where it is easiest to place.

MR. BOLNICK: Mr. Carbone, you mentioned that you have not seen any loss ratio differences at the breakpoint between medical and guaranteed issue. Would you verify this and give some insight as to why you think this happens?

MR. CARBONE: We underwrite our products with a reasonably stringent preexisting conditions clause, and we only offer guaranteed issue in those jurisdictions where we are allowed to enforce that clause.

MR. BOLNICK: When you say "enforce," what do you mean?

MR. CARBONE: We administer claims or our carriers administer claims according to the letter of the policy on preexisting conditions.

MR. BOLNICK: Mr. Winkelstein, do you see any difference between medical issue and guaranteed issue loss ratios?

MR. WINKELSTEIN: I do not because there are other influences that the John Alden database was not able to separate. Some of our best offices were in states where we had to give no loss/no gain, and we did not medically underwrite. Therefore, we did not see much of a break in experience between the size that we guarantee issue and the size that we medically underwrite.

MR. BOLNICK: My company saw a full fifteen to twenty points difference between guaranteed issue and underwritten business from the same distribution system. We couldn't sell both products at the same price, so we stopped writing guarantee issue.

MR. PETERSON: When you talk about medical underwriting I assume you are talking about a short form nonmedical application. Are you also obtaining a physical or paramedic exam?

MR. WINKELSTEIN: John Alden made pretty frequent use of APSs and even ran MIBs on insureds.

MR. BOLNICK: We do not use MIBs and APSs. We just take the individual's word for his health. Our approach contains carefully structured underwriting questions.

MR. PETERSON: Did you ever use a paramedical exam to flesh out the nonmedical questionnaire?

MR. BOLNICK: No.

MR. WINKELSTEIN: No.

MR. PETERSON: What alternatives or options do you have if four out of five applicants in a five person group qualify? Do you just not bid it, raise the rate, rider them, or exclude them?

MR. WINKELSTEIN: John Alden would rate up people, rider people, and immediately accept the four who qualify and not accept the other person or possibly accept him with some kind of rider. There was a complete choice. I believe Blue Cross/Blue Shield accepts or rejects a group. It does not exclude any members.

MR. CARBONE: We will accept the satisfactory individuals. We will sometimes accept the unsatisfactory individual if on balance the case passes the selection thresholds. We will on occasion rider out a condition that may translate an unacceptable risk into an acceptable risk.

MR. BOLNICK: Celtic does only accept/reject underwriting. If you have five people, only four of whom qualify for acceptance, the chances of writing the group are pretty small.

Some states are taking the position that you cannot underwrite individuals. Some states even tried to take the position that you can't underwrite at all. This was true until we explained that all their law said was that an insurer couldn't decline an individual member of the group because he was unhealthy and didn't limit the criteria used to accept or reject a group.

MR. DANIEL McCARTHY: Do any of you have experience in either medical underwriting or in guaranteed issue with lifestyle questions? Smoking or nonsmoking would be the most obvious.

MR. CARBONE: No.

MR. WINKELSTEIN: No.

MR. McCARTHY: How is it used? Is it used as a rate classifier on a guaranteed issue situation or further evidence on a medical questionnaire?

MR. BOLNICK: Is there anyone here who could tell us about any company that gives a 10 percent discount for nonsmokers?

MR. JAMES L. LOFFREE: Manufacturers Life has a 20 percent load for smokers and a 10 percent discount for nonsmokers using the usual one-third, two-thirds mix as being average.

MR. BOLNICK: Do you have any data to make us feel comfortable with the discount?

MR. LOFFREE: We are relying on a consultant.

MR. CARBONE: Do you apply those loadings and discounts to individuals within the group, or do you load or discount the group on a composite basis?

MR. LOFFREE: We use composite rates from ten lives and up. Below that we use individual, separating employees and dependents.

MR. WINKELSTEIN: John Alden would not allow coverage for someone who applied and was currently pregnant until she gave birth.

MR. BOLNICK: We allow a limited number of existing pregnancies within a group. The number varies depending on group size. Over the limit, we reject the group. The whole family will be rejected if there is a pregnant female. If you would insure anyone in the family, you will likely be insuring the newborn even if you don't cover the mother.

MR. O'NEIL: Is there any control in underwriting on how many carriers a particular group could have had in the last five years? We have a group in the larger group market which had three carriers in five years. We don't want to consider them. I was wondering if you

could do anything in the small group market?

MR. CARBONE: We don't, but we've been talking about it as one possible control. Of course, if you buy the tiered pricing argument, then you can argue that somebody who switched carriers frequently in the recent past is actually a better than average risk.

MR. HIRST: Do you use any different underwriting criteria for new entrants into an existing group versus the initial underwriting? Do you lean towards guaranteed acceptance of new employees or dependents?

MR. WINKELSTEIN: At John Alden, if a group qualifies for guaranteed issue, which is basically having five lives or more, all new entrants would be allowed to have the same guaranteed issue requirement. However, late entrants would have to produce evidence.

MR. CARBONE: Our most common approach is the guaranteed issue for on-time new additions, regardless of whether the original group was underwritten or not.

MR. BOLNICK: We underwrite the new entrants just the same as new business. If you don't, you are leaving a hole by keeping an unacceptable individual out of the original group and adding him after issue.

We apply slightly different standards to new entrants than to new business because there are reasons for being a late entrant. Switching jobs is probably the biggest reason. However, many people switch jobs because the wife becomes pregnant. When this happens, the pregnancy issue previously discussed becomes important. Turning down a new entrant almost always loses the group and gets the agent upset. We therefore take a slightly different view of the pregnancy risk on new entrants.

The other interesting characteristic seems to be a certain self-selection process for new entrants as opposed to late entrants. People who are switching jobs seem to be generally healthier. They are switching jobs to become upwardly mobile economically. This also supports some "loosening" of underwriting criteria for new entrants.

MR. WILLIAM SONNLEITNER: If you have a group initially guaranteed issue and it falls to the size levels of individual underwriting, what do you do to add on these?

MR. WINKELSTEIN: At Alden, if a group fell below five lives, it would not be considered a guaranteed issue group anymore. All new entrants would have to produce medical evidence.

MR. CARBONE: Our trusts require underwriting of on-time new additions and require medical evidence all the way, so there's no such thing as dropping back below that threshold.

MR. JEFFREY GATHERS: Mr. Carbone, you've mentioned that your preexisting conditions exclusions are very important in your financial results. Is there anything about the language of that provision that is different from what a number of the other carriers might be using?

MR. CARBONE: We tend to use either a 6-12 or 12-12 exclusion, which is a little bit more stringent than things that we are used to seeing elsewhere. We define the timetable for establishing a preexisting condition as being either six months or twelve months prior to coverage.

MR. GATHERS: Is this only in terms of having received medical treatment?

MR. CARBONE: That's with treatment, advice, consultation services, and so on.

MR. WINKELSTEIN: John Alden used a 6-24 or six months treatment free which could end with the first day of coverage. Therefore, it was actually a 6-6-24. Several states required the 24 cut back to 12. A part of the John Alden definition of preexisting conditions was "symptoms evident." It was more legal evidence in our favor if things ever came to court.

MR. BOLNICK: Would the panelists explain their position about whether TPAs are good, bad, or indifferent.

MR. CARBONE: For most companies, administering small group business through an appropriately selected and qualified TPA is one of the smartest moves to make. Administration through an inferior TPA is probably an express lane to failure. In between comes the alternative of doing it yourself, which is a viable alternative only for those companies willing to make the investment and commitment to building the specialized systems necessary to administer this class of business.

MR. WINKELSTEIN: If the carrier is willing to devote time and resources to managing mini-groups, being aware that mini-group is a very different product, it is better to have your own system than a TPA. You need more efficiency in a larger group's system. In certain areas you need a claims department which is aware of preexisting conditions, aware in what would be called post-plan underwriting or the claim adjudication process - more severe in mini-group than in true group.

There are bad TPAs. A good TPA on a scale would be indifferent. The TPA is operating to produce business. TPAs typically get paid on a percent of the premium in force. They're under financial incentive to write business and keep it on the books. Their financial incentive is not to turn down a lot of business at the front end. A lot of TPAs, to their credit, do things more intermediate than long term. However, as a carrier, if it's my money I want better control over it.

There is a model administrators bill which says that a third party administrator cannot receive loss ratio incentives if it pays claims. One of the things that people in mini-group will find out is that it is very good to have coordinative functions; for example, a claims department, an administrator, and a marketing group set up in the same

organization. You want to get the underwriting records before a claim is paid. The claims people at John Alden would advise us which types of groups were making a lot of claims. They advised us on abuse so that we could correct our policy language.

MR. BOLNICK: We have talked about features to control small groups which are different than those for large groups. With a third-party administrator performing the purely "paper-pushing functions," we spend our time designing products and the rules by which administration is performed, and then in turn auditing the administration. We are concerned only that the product works precisely the way we plan. Separating the monitoring and control functions from the day-to-day administration is enormously helpful. A third-party administrator helps to avoid the problems in trying to figure out how to administer business. You can avoid spending management's time and effort in the wrong places.

MR. HAWKINS: TPAs have an interest in what goes on in the future and what goes on right now. It is of little use to a TPA, to have a carrier go great guns for a couple of years and then have the carrier quit or go down. I understand that some of the better administrators have actually hired actuaries on their staff.

A TPA can help in marketing the product. Also, if you leave the small group product all in the company, it will be like a stepchild. You might make a little money on a little business, but it's never going to be a big part of your portfolio. It won't do well in the group department or the individual department with universal life and all the other products the company has introduced.

MR. PETERSON: How do you envision the rise of HMOs and the concerns of the large group writers with competition from self-insurance, PPOs, HMOs, and other carriers affecting your particular business in the two to nine market?

MR. CARBONE: It's a revolution, in the manner in which healthcare services are being delivered in this country. It is going to have an impact on every segment of the industry. We are uncertain as to how to apply the HMO or PPO approach to small group. In the market, you seldom have a sufficient mass of individuals insured in any specific geographic territory to make yourself a viable customer. The favored approach is a nonproprietary network, hooking into commercial PPOs or getting to utilization management through a number of organizations that are marketing this as an independent stand-alone. In terms of HMOs, we are currently experimenting with marketing a dual choice product.

MR. WINKELSTEIN: We are right in the middle of that at Blue Cross/Blue Shield. As previously stated, we have an HMO in South Carolina; our standard small group package, which covers groups from two to forty-nine lives, is a PPO program. The PPO program has a lot of concurrent preadmission review. We try to have as much

control over the providers as possible, both in what they charge the patient and also in how they perform the care. This gives us a competitive product in the small marketplace in South Carolina. We can offer a program that, when an insured utilizes one of our preferred providers representing over 25 percent of the providers in the state, he receives effectively 90 to 95 percent coinsurance at a price everybody else is charging for 80 percent coinsurance. We also control the increase in physician fees.

MR. BOLNICK: In general, what I have seen happen in the Alternative Delivery System Market has been directed mainly at larger groups. Small group has been relatively untouched. That doesn't mean Alternative Delivery won't be important. Over the next three to five years, the major competitive battle in small group will be fought in the area of provider arrangements or utilization review. It will not happen as fast as with larger groups.

MR. McCARTHY: When you are thinking about marketing dual choice option with an HMO, it seems that in groups of this size one of the problems is that when the group moves it goes to some place where it doesn't have that option anymore. Have you thought about that issue, and put it in dual choice?

MR. CARBONE: Yes, we have. We look at the other side of the coin and say, "isn't that a nice way to retain your groups?"

MR. GATHERS: Mr. Carbone, have you resolved the underwriting differential between families who would be inclined to go the HMO route versus the conventional insurance route, and do you have a deal with your HMO to help trade that back and forth?

MR. CARBONE: We have not resolved the problem or proposed a solution. We are talking with the HMOs on precisely that point.

MR. HANDLEY: Will you work with federally qualified HMOs, and what will you do from the standpoint of the ratings, since a federally qualified HMO can't combine the experience in terms of setting the rates? Will you look at age-specific type rating, where somebody under thirty gets one rate and the forty to forty-four year-olds get another rate?

MR. CARBONE: We are working with HMOs which are federally qualified, but we haven't insisted on that. We will have rate structures which are identical in terms of their parameters on both the HMO and on the commercial side.