RECORD OF SOCIETY OF ACTUARIES
1986 VOL. 12 NO. 4A

ASSOCIATION GROUP

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- Market
- Products/plan design -- life, health
- Administration
- Underwriting
- Types of delivery systems

MR. JOHN C. ANTLIFF: Association Group in our context refers to employee benefits rather than casualty coverages. In addition to the usual group arrangement involving the insurer, the employer or plan sponsor, and the insured people (the employees or union members), there is an additional player, the association, and usually a Third Party Administrator (TPA). The administrator typically is also the promoter of the association group case, and sometimes the association itself is the administrator. In fact, it's sometimes more accurate to say that the TPA is really the association. That can occur when the TPA organizes and controls the association.

The existence of these additional players has interesting implications. For example, in the area of market research, the association or the administrator researches the benefit needs of the members of the association, whereas the carriers will research the needs of the associations and the administrators.

Association group can differ markedly from regular group also in underwriting. Associations of individuals and small member firms require underwriting

techniques which are similar to individual policies, including evidence of good health. The politics within the association may prevent you from using certain kinds of underwriting rules or certain kinds of rating classifications.

Association business also differs with respect to conservation. Many associations tend to be loyal primarily to a particular administrator, and the administrators frequently tend to be loyal to a particular carrier. The members presumably are loyal to the association, but unfortunately that's not always the case. It would be smart for the carrier, when working with an association, to consider the value of the sponsorship of that association.

Our panelists are going to discuss two contrasting types of associations, associations of individuals and associations of member firms. The sale in an individual member association is made to the individual, through the association, after the carrier has made a sale to the association. The sale to associations of member firms is made to the employer, again through the association with its endorsement, after having sold the association.

I would like to give you some statistics on the extent of the association group business. I will use Life Insurance in force, since these data are readily available in the Life Insurance Fact Book, which does a special survey every five years. At the end of 1983, the most recent five-year period for which data are available, the insurance in-force was $80 billion, up 60% over the five year period from 1978, when the in-force was $50 billion. That, in turn, was up 50% from the $33 billion in force at the end of 1973. For comparison, if you look at the data on total Group Life, you find an increase from 1973 to 1978 of 75%, which is greater than the 50% increase in Association Group. During the next five year period, ending in 1983, regular group grew 80% versus 60% for association group. There are two explanations why association group business hasn't grown quite as rapidly as regular group. The first is that payroll inflation has a greater beneficial effect on regular group than it does on association group, because many association plans have a nominal flat amount of Group Life Insurance, since the plan is driven by the Medical product. The second reason is that associations tend to lose large member firms, especially large member firms that have had favorable experience.

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There are only about 200 national associations of individuals. This compares with 70 large national trade associations and 300 smaller national trade associations. In addition, there are several thousand state, regional and local trade associations, not to mention about 700 franchisees or franchisors. The American Society of Association Executives (ASAE) surveyed its members in 1984 to determine the types of associations that sponsor insurance, the types of employee benefits and P/C coverages that they commonly offer, their reasons for sponsoring insurance plans, and their future intentions as to new programs. Questionnaires were sent to the CEOs of 1,000 randomly picked associations. The response rate was 47%. Of the 470 responders, 57% (270 associations) said that they presently sponsor one or more insurance plans. Their reasons for sponsoring insurance, ranked in importance, include:

1. To gain and retain members. The associations were formed for purposes essentially other than the desire to obtain insurance.

2. Availability, on the Casualty side. Because of the hard market for Professional Liability and General Liability, it's a real service to the membership to make this coverage available on an association basis.

3. Cost savings, through their mass purchasing power.

4. Simple convenience for the members.

5. Income to the association.

As far as the types of associations that sponsor insurance, the 57% breaks down this way. Among the individual membership societies, 56% sponsor at least one plan. Among the trade associations, it's 65%. There is a miscellaneous category which brings the average back to 57%. The trade associations have a higher indication of interest presumably because they are more commercially oriented.

In terms of the geographic scope of the association, only 50% of the national associations, 65% of the regional associations and 70% of the state associations sponsor a plan. The state associations tend to have a higher percentage

because the membership is more homogeneous than that of the national associations, and, therefore, the state associations have better control because they are closer to their members than are the national associations. On the other hand, only 43% of local associations sponsor at least one plan. Perhaps they are just not large enough in terms of potential volume, or they just don't have the resources for the undertaking.

The variation of interest by size of the budget of the association shows the same thing. The medium sized associations have the highest interest, 68%. Only 53% of the largest and 45% of the smallest of the five size brackets showed an interest.

Which coverages are the most popular? Among the 270 associations sponsoring at least one plan, 67% sponsored a Comprehensive Medical plan; 55% sponsored a Life Insurance plan; 54% sponsored a Disability Income plan, which may be somewhat of a surprise in comparison with the 55% on Life; 34% had a Dental plan; and only 17% had a retirement plan. Member participation was 30%. Of the Property/Casualty coverages, Workers Comp was the most frequent. Forty-nine percent of the responding associations have a Workers Comp plan; 35% have Professional Liability and Commercial Liability. Participation by members in the P/C coverages runs around 33%.

MR. RICHARD L. VAUGHAN: I will first discuss market, product and delivery with respect to associations of employers. Later in the session, I'll discuss underwriting and administration.

There are two aspects that I feel are important to include in any discussion of this kind of product. One is the financial structure that's used to provide the product, which I include under delivery. The other item is rate structure and rating techniques, which I include under underwriting.

ANALOGIES

Before discussing market, product and delivery, I do think it is important to have an overall mental construct, or perhaps a mental analogy, to guide our thinking about trade association plans.

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A common analogy for trade association plans or multiple employer trusts is to liken them to large single-employer plans. This analogy may condition the expectations of the association. For example, the association may feel that "group insurance" will permit uniform rates. This can lead to difficulties, as we will see later. The analogy may also condition the expectations of the insurer. For example, an insurer that has a large block of large single-employer group business may feel that the reporting, administrative and renewal rating procedures can be borrowed with little change from its large group operations. This is also a problem because the effective buying unit for the trade association plan is not the association itself, but rather the member firm. So, the analogy of a trade association plan to a large single-employer plan is seriously inaccurate.

A more accurate analogy is to think of a trade association plan as similar to a small insurer and think of the actual insurer as similar to a reinsurer. If this is the mental construct with which we approach trade association plans, then it will temper the expectations of the association. For example, the association will realize that a refined rate structure may be necessary to compete effectively without adverse selection. This analogy will also make clear to the insurer and the association the need for special treatment to attract and retain a profitable book of business.

Occasionally, in what I call "high-affinity" cases, where the group is very cohesive, an association does resemble a large single employer. Under almost all other circumstances, the analogy of an association plan to a small insurer is the better of the two analogies, and it helps to explain many aspects of product design and delivery. The high affinity cases (an example is an association of franchisees who feel a very strong loyalty to their franchisor and to the overall organization and who therefore participate to a very high percentage) run counter to many of the generalizations that we'll make about trade associations. They're really the exception which proves the rule.

Another mental construct is what I call the Black Box analogy. A black box is any device that accepts input and produces output, but the internal structure of which isn't known to the observer. He simply sees what happens to the input -- how it comes out.

Put yourself in the position first of the association executive as observer and then of the association member. To the association executive, the insurance plan is a black box. It happens to contain the insurer and the administrator, but the executive thinks of it as being the administrator. He evaluates the administrator on the basis of the performance of the black box as a whole. Thus, the administrator has to be very careful to "underwrite" the insurer to make sure that the insurer's performance in administration, financial risk taking, plan design, etc., meets the appropriate standard, since the administrator receives any complaints from the association. To the association member, the insurance plan is also a black box, this time bearing the name of the association. Of course, inside the black box are the association, the administrator, and the insurer. But the member simply sees the overall performance of the plan and relates any difficulties or complaints he may experience to the association. The association, in turn, funnels them on to the administrator. Therefore, the administrator winds up assuming the responsibility for the proper functioning of all three parties that ultimately service the member.

UNDERWRITING AND COMPETITIVENESS CYCLES

An important circumstance related to marketing is that the trade association market is affected by the so-called underwriting cycles we hear about in connection with Property and Liability Insurance. And it's also affected by what I call competitiveness cycles, which are specific to individual trade associations.

The "underwriting cycles" have the following characteristics:

1. They affect whole lines at once, for example, Group A&H or Property and Liability, but they don't necessarily affect both of those groupings at the same time.

2. They are driven by fluctuations in the capital available to support risk assumption relative to the number and size of risks that want to be insured -- in other words, by industry "capacity," which is often regulated by looking at the ratio of premium writings to surplus. If something happens to cause premium writings to increase, perhaps an upward

adjustment of rates based on changing expectations, then capacity drops (measured by the number of entities which may be insured). Likewise, if losses have taken place in the industry, capacity drops because there is less capital.

3. The effect of these underwriting cycles is magnified for associations, because the insurers perceive that when they undertake to insure an association they are assuming an adverse selection risk in addition to all the normal risks of the coverages themselves.

4. The period of these underwriting cycles tends to be several years in length from one high to another -- maybe six years or so.

"Competitiveness cycles" are observed particularly in trade associations. I don't recall that we have observed them in our professional associations. Competitiveness cycles affect single association plans, particularly if they are in single locations. They're not synchronous from one plan to another. In other words, we could have a very fine period with a plan in one city, whereas at the same time another city was having competitive problems, even with the same insurer involved. These competitiveness cycles are driven by the time lags between establishing rates, actually putting the rates in force and starting to collect premium on the new rates, and the emergence of experience, as well as by the time necessary to analyze the experience and adjust the rates. They are also driven by actions of competitors. These cycles can cause associations and administrators, to take too much credit when things go well and to take too much blame when things go poorly. They can cause large swings in the participation of plans, particularly where the loyalty to the association is not terribly strong. And, the time period of these from one high to the next is somewhere on the order of two years. So in assessing the market for this product, bear these cycles in mind, especially when looking at the experience of a takeover trade association plan.

MARKET

The market for trade association plans consists of trade associations proper, that is, organizations of employers engaged in the same industry. They may be

national, state or local associations. It also consists of associations of franchisees of a single franchisor. The type of plan that services franchisees is otherwise entirely analogous to trade association plans. Another component of the market is associations of distributors of the products of a single manufacturer. For example, the manufacturer of a large yard equipment item might enroll hardware stores that sell its product even though the hardware stores also sell many other things. Another type of plan that is very similar to a trade association is the Chamber of Commerce plan. These plans present additional difficulties in management and in rating because they're so heterogeneous, but they are a very important part of our business, and I'm sure that there's a big market for them. And then there are miscellaneous groupings. For example, in California we have an organization called the Southern California United Way Unemployment Insurance Trust in which non-profit agencies have joined together in order to provide themselves with unemployment insurance. Some states permit municipalities or non-profit organizations to go outside the monopolistic state fund for unemployment insurance, and we happen to have done that. There are similar organizations in other states that provide Group Medical and other coverages, just like any trade association.

PRODUCT

The product emphasis and design in the trade association market is driven by the needs of small employers to provide benefits. Because they compete in the labor market with larger employers, many small employers feel compelled to provide benefits similar to those provided by larger employers. We're talking primarily about welfare benefits, Life, Disability Income, Medical, and Dental, and the insurance programs offered by trade associations tend to include all of those benefits.

However, the product emphasis in most trade associations is definitely Medical Insurance. The association executive will evaluate the performance of the administrator and the underwriter in terms of their Medical plan stability, the smoothness with which their Medical rates change and their competitiveness in the marketplace. Weekly Income, LTD and AD&D are secondary coverages. This is in a sharp contrast to professional and individual membership associations, where Disability Income is a very big coverage. Life Insurance

is normally packaged; in other words, there's normally a requirement that a certain small amount of Life Insurance be purchased with the Medical. If it is not packaged, and the amounts are subject to selection by the individual employers, there is some risk of adverse selection. If it is packaged and properly underwritten, the Life Insurance becomes a distinctly secondary line in the minds of the people dealing with these plans. It receives little attention, but it generates reliable profits. Dental may also become a secondary line receiving little attention, but not necessarily generating reliable profits.

Small employers may have fairly severe cost constraints but still wish to offer something to their employees. Therefore, it is necessary to offer not just a single plan in each coverage, but a portfolio of Medical plans covering a range of costs. We prefer to set up a coherent portfolio, so that employers can read a single brochure to find out most of the details of all of the plans in the portfolio. This enables them to comprehend easily how the plans differ in the deductible, in the out-of-pocket limit, possibly in the coinsurance percentage, and possibly in cost containment features such as special per confinement deductibles. A word of warning here: a common situation that arises when a trade association plan changes from one carrier to another is the perpetuation of old plan options. For example, if an association changes from a Blue Cross to a commercial carrier, certain plans may have to be grandfathered for political reasons. In other words, the new carrier may wish to have a comprehensive Medical plan design that is coherent and consistent with that carrier's adminisistrative capabilities, and that is more up-to-date than the existing plan. But it may be necessary to grandfather the plans that existed prior to the takeover at least for a period of time. It's wise to try to force the employers into the active portfolio plans after two or three years. Otherwise, you run the risk of having plans which provide unique benefits attractive to certain employers who will gradually be the only ones remaining in the group. Then you'll really be in political trouble, as well as suffer underwriting losses.

DELIVERY -- FINANCIAL STRUCTURE

The delivery system for trade association plans differs greatly from that of individual membership associations. The first difference is that you must have

face-to-face contact in order to be effective in selling to a small employer unit. For example, about ten years ago we had a national trade association operating out of our Milwaukee office which we tried to market by direct mail in the state of Ohio. We received one response. On the other hand, other methods of marketing kept that program stable. These methods include trade conventions, where you set up a booth and you contact the people who come to the trade convention directly. Or, you may use employees of the broker/ administrator, especially with an association that's localized to a particular city. Agents of the insurer are another possibility. In some of our cities with Chamber of Commerce programs we work with independent sub-brokers. Employees of the association itself may generate leads and bring them to the administrator. Yet another possibility for a number of trade associations is for the association to own all or part of a captive agency. In fact, one case we saw was 51% owned by the association and 49% owned by the insurer, and the insurer provided the administrative personnel and captured almost all the profits through the expense loadings. Direct mail, which is the classic approach for professional associations, seldom works, by itself, for a trade association. As usual, an exception is the high affinity group, a group with unusual cohesiveness. Direct mail is customary for resolicitation, after people have become familiar with the program or after they're in the program and upgraded benefits are proposed.

Finally, a few remarks about financial structure. There is a strong preference for fully insured plans. There are many associations where the trustees of the insurance program are themselves executives of large employers. The typical example is Chambers of Commerce, where high executives of large local firms often become trustees even though the Chamber primarily serves smaller employers. They are familiar with ASO or other self-insured funding methods from their own companies, and they ask about the applicability of such funding methods to the Chamber program. We feel that such approaches are not generally feasible in the absence of either (a) some form of subsidy, in other words, a subsidy that the members of the association member firms receive from a central association if they participate in the plan, which is practically impossible; (b) an assessment mechanism, also impractical; or (c) a pre-existing surplus which has accumulated under the plan or from some other source, plus a secure way to retreat back to a fully insured conventional group insurance plan if the

surplus is exhausted. Given the thinness of the market for such plans, it's practically impossible to see those conditions in existence for Group Medical.

Given that the plans tend to be fully insured, there's also a preference for retrospective experience rating, either a participating plan where the retrospective experience rating is through the dividend calculation or a technically non-participating plan in which the retrospective experience rating is built right into the contract. And this is true, even if the rates for a non-par or fully pooled structure might be mathematically equivalent. The reason for this is that the decision-makers within the association are either members of an insurance committee or the financial executives of the association, who feel pressure from above to monitor their performance. They find it more comfortable if they buy a participating contract with a loading built in for dividends. If, after the year goes by, they find they had a bad year and they paid the loading even though they could have had a slightly lower rate by purchasing a non-par contract from someone else, nevertheless they feel comfortable because their own group's experience generated the situation. On the other hand, if they purchase a non-par contract, they feel much less comfortable with their decision after a very good year because the premium is gone. They feel exposed to the criticism that they didn't look hard enough for the best quote at the beginning of the year. So, it's much more comfortable for them to assume the risks of the par contract than the non-par. However, the marketplace doesn't always permit this. Our company has plenty of examples where we've tried to obtain a par contract from an existing insurer and it hasn't been available, and yet we've remained with that insurer because there's a risk to changing carriers on plans of this nature.

The association plan, both trade and professional, is the last bastion of the Claim Stabilization Reserve (CSR). Some years ago, insurers attempted to persuade employers to permit any accumulated surplus to be held in a Claim Stabilization Reserve, which would permit a lower risk charge and possibly would be credited with a competitive rate of interest and might have some other advantages for the employer. But most employers prefer to apply their dividends to the next year's premium or get them out in cash. However, in the association marketplace, not only do you have the normal reason for a Claim Stabilization Reserve, which is a low risk charge because of the additional

protection for the insurer, but also you have reasons that are specific to the association. A Claim Stabilization Reserve

- permits flexibility in renewal rating when there may be competitive threats from other associations or from other insurers in the marketplace that are competing for the same small employers.

- permits underwriting liberalization if the surplus has accumulated and some of it can be committed to experimenting with either changing the plan or changing the underwriting rules, which the insurer might be very chary of doing otherwise for lack of experience.

- avoids small distributions to members, which are a nuisance.

So long as the Claim Stabilization Reserve exists and is positive, it gives the association management, in connection with the administrator, a certain amount of leverage or control to help keep the plan competitive.

There are some outstanding questions that have to be answered for each plan separately, such as, How do you set a target level for a CSR? When do you use it to lower rates? Will anyone be blamed if the CSR starts, gets fairly large, and then disappears, which can happen very easily in the Medical area? How much should the risk charge be adjusted? What is too much adjustment or too little? And should there be a dual CSR where part of it provides protection to the insurer and part of it is held by the insurer in trust; the insurer can't dip into it to cover losses, but it allows the association to stabilize its rates?

One last question is whether coverages should be combined for experience or expenses, or whether they should be placed with a single carrier or several different carriers. The real consideration here is the degree of overlap in participation. If Life Insurance is a required coverage in order to have Medical, then certainly I think no one would object to having the Life and Medical combined for experience and having a small subsidy which often develops from the Life flow over into the Medical at renewal rating time. On the other hand, if you have coverages that are distinctly voluntary and separate and have different pools of participants, such as perhaps Disability Income and Medical,

then it's a good idea to keep the Disability Income separate. In that case you're free to go with a different carrier entirely.

MR. BRUCE A. CARLSON: I'd like to preface my specific remarks about markets, product and delivery system with some comments about our company, how we're organized, and what our strategy is. We have enjoyed considerable success in the Association Group area over the years, and some of the reasons for that success have to do with our method of organization and our strategy.

GENERAL

North American Life and Casualty Company (NALAC) is a stock life insurance company located in Minneapolis, Minnesota. We are wholly owned by Allianz Versicherungs of Munich, West Germany, the eighth largest insurance company in the world. NALAC is licensed in 49 states and Canada. In 1984 NALAC formed Preferred Life Insurance Company of New York, a wholly owned subsidiary. The motivation for forming Preferred Life was to allow us to solicit through Preferred Life the New York members of those associations which NALAC could not solicit. In New York NALAC can only solicit members of professional associations which are engaged in the same occupation or trade. NALAC cannot solicit non-professional associations or professional associations not engaged in the same occupation or trade. Without Preferred Life it would be difficult to obtain the sponsorship of large national associations with New York members.

Within NALAC we have five independent profit centers:

1. Individual Marketing, which sells primarily Universal Life and Deferred Annuities through a network of approximately 30 regional sales offices and 42 managing general agents.

2. Reinsurance, which develops and sells reinsurance and related services for Individual products, particularly substandard facultative underwriting.

3. Scholarship Operations, which distributes educational scholarship-savings products, similar to mutual funds, in Canada and Central America.

4. Financial Services, which develops insurance related products for distribution through financial institutions such as banks, savings and loans, stock brokerage firms, mutual funds, and credit unions.

5. Mass Marketing, where all of the Association Group business is marketed.

The Mass Marketing profit center is divided into four independent and distinct marketing departments which may be viewed as mini-profit centers. Those departments are:

1. Special Markets, which assumes group reinsurance from approximately ten quality reinsurance intermediaries and underwriting pool managers.

2. North American Special Risk Associates, which specializes in voluntary purchase employer/employee business.

3. Self-Funded Group, which develops and markets Specific and Aggregate Stop Loss Insurance with ancillary Life, AD&D, and LTD to employers of from 25 to 1000 employees.

4. Association Group, which develops and markets products primarily to sponsored professional associations.

NALAC has been in the Association Group market for over 25 years. We insure more than 100 associations, with over 3,000,000 members insured. In 1985 we had over $95,000,000 of earned premium in Association Group.

Within Mass Marketing we have enjoyed considerable success over the past several years. There are key elements of our strategy which I believe are reasons for that success. These elements of our strategy apply to the Association Group Department as well as the other three Departments.

First, we are profit driven. We measure it, monitor it, and share the results with our sources of business and reinsurers. We require each source of business to be profitable. If a particular source's total book of business is not profitable, we work with that source to correct the situation. If we cannot

work with the source to correct the situation, we terminate that source and all of its business.

Our marketing people are profit driven. A good part of their compensation is based on the profit results for Mass Marketing. Because of that profit motivation, we give our Marketing Managers final underwriting authority on a particular case. The Marketing Managers, as we call them, are the key people within our organization. All others (i.e., Underwriting, Actuarial, Legal) are support people helping the Marketing Managers make those underwriting decisions.

Second, we are underwriters, not administrators. We deal exclusively through 30 to 40 Third Party Administrators (TPAs), who typically also function as brokers. We refer to them as Broker/Administrators. These are the sources of business I referred to earlier. They, in fact, are our customers. (We have very little direct contact with the individual members themselves.) The TPAs bill and collect premium, issue certificates, and in many cases have marketing departments to handle the development and mailing of direct mail solicitations. The TPAs may pay claims, depending on the type of business being underwritten (mostly Medical). They may also do some simplified issue underwriting for us. NALAC is the risk taker behind the scenes, having little direct contact with the ultimate buyer.

We deal through TPAs for several reasons:

1. Their primary business is administration. Therefore, they do a better and more efficient job than we can. This also eliminates the space and overhead associated with a large staff of administrative people.

2. Farming out the administration gives us the flexibility to rapidly expand into new markets or products without having to develop the staff and computer systems to support that market or product. We simply find an Administrator with the staff, systems, and expertise to handle the administration for us. We can also retreat from a market very quickly without having to deal with the problems associated with staff terminations.

3. The business from TPAs may be better quality business than business from brokers. A broker will typically put a case out for bid at renewal time, forcing the carrier to keep its margins slim in order to retain a case. The Broker/Administrator won't move a case to another carrier unless a serious problem exists. It then incurs additional expenses of reissuing certificates. The Broker/Administrator is more concerned with having a carrier that is a stable, consistent underwriter -- one it can work with.

4. Allowing the TPA to collect premium and, in many cases, pay claims shifts a good deal of the legal risk to the TPA.

The growth of Mass Marketing over the last ten years in terms of people and earned premium can be seen from the following chart:

Year	Net Earned Premium (000)	Staff
1976	$ 18,706	60
1977	17,944	50
1978	19,264	44
1979	20,836	45
1980	26,339	47
1981	36,019	52
1982	53,427	56
1983	80,203	52
1984	105,756	56
1985	130,774*	62

* Approximately $95,000 in Association Group

Note that our earned premium has grown about 700% while staff has grown only slightly, reflecting our reliance on TPAs. Our growth in profit has paralleled the growth in earned premium.

MARKET

As was mentioned earlier, NALAC markets primarily to professional associations as opposed to trade associations or METs. A professional association has the following characteristics in common with trade associations:

- Persons in the same occupation
- Members scattered over a wide geographic area

- Continued resolicitation required to keep a healthy body of members
- Association support and sponsorship needed to have a successful campaign

Differences between trade and professional associations are:

- A professional association deals with individual members as opposed to employer members
- Premiums charged are typically graded by age
- Extensive use of evidence of insurability on each member

Our target market is the national association of at least 10,000 members. We also look at:

- State associations, where you typically get better penetration due to the closer affinity of the members.
- Financial institutions, with products marketed to specific needs of mortgage customers, savers, checking account customers, and credit card holders.

In order to successfully market to members of professional associations, you need the endorsement of the Association. You may be able to rent its mailing lists, but without its sponsorship your chances of generating a successful mailing are greatly reduced.

What's in it for the association? Why should it give its endorsement to one or more carriers to solicit its members? There are several reasons:

- Insurance benefits are one way to attract new members and to provide an inducement to current members to maintain dues.

- In some cases there is a profit motivation in that excess profits on the business written may be shared with the association via either a profit sharing formula or a retention format.

- There may be additional fee income to the association for renting its lists.

PRODUCT DESIGN AND DEVELOPMENT

We are not product manufacturers. We do not have shelf products that we offer to associations for sale to their members. Rather we work with the administrator and association to develop a program that best suits their needs. Since the TPA will handle most of the administration, the product development function reduces to pricing the risk and drafting and filing the necessary policy forms.

Most of the products we sell to Associations are Term Life, Accidental Death, AD&D, Disability Income, and Business Overhead Expense insurance with the following ancillary products: Hospital Indemnity, Cancer Indemnity, Medicare Supplement, CHAMPUS Supplement, Trade Association Medical, and Long Term Care/Skilled Nursing Indemnity.

As I mentioned earlier, we are profit motivated and compensate our marketing people in good part on the profitability of our in-force business. We may also have profit sharing arrangements with the other entities that have influence over our business, namely, the administrators and associations. Three such arrangements are:

1. A contingent commission agreement with the administrator whereby any profits in excess of x% are partially shared with the administrator. We cannot do this when the administrator pays claims, because that would violate the administrator statutes.

2. A retention agreement with the association whereby NALAC keeps a fixed percentage for expenses and profit, and any excess profits go back to the association. In this format you effectively put a cap on your profits, but your losses can be unlimited except to the extent you can recapture some of them through loss carry-forward provisions. Due to competitive pressures we are seeing more cases, even small Life cases, being put on a retention formula.

3. Finally, a three-way agreement in which any excess profits are shared equally among NALAC, the association, and the administrator.

DELIVERY SYSTEMS

We currently solicit the professional association members exclusively by direct mail. We will be experimenting with use of a broker in a face to face sale with a long term care product we are currently working on, but I have no results to report at this time. We are also investigating using celebrity endorsements, interactive cable television, and telemarketing. I have heard from other sources that telemarketing can be quite successful, especially when used as a follow-up to a direct mail solicitation.

The direct mail campaign is typically handled by direct mail professionals working on commission, usually in the marketing department of a TPA. Alternatively, the mailing can be contracted out. These professionals test various factors associated with the mailing such as the packet itself, timing, target audience, follow-up, etc. Obviously the association's sponsorship is a critical factor. A small test mailing (of at least 10,000) will be tried if the case involves:

- a new approach to a mailing
- a new TPA
- a new product
- a new packet to an established association
- an association which has not been previously offered an insurance program

To determine if a mailing is successful, we are not so much concerned with the response rate as we are with what we call the TAP/MC ratio (Total Annual Premium/Marketing Cost). We consider the mailing successful if a ratio of 3:1 or higher is achieved. It is difficult to make money if the ratio is less than 140%.

Who pays the promotion costs? We use several arrangements:

1. The Administrator pays 100% but then receives a higher first year commission on the premium generated. This has the effect of shifting the mailing risk to the administrator.

2. Cost sharing between the administrator and carrier. This is either a 50/50 sharing or an arrangement by which the carrier pays for all costs associated with the printing and the administrator pays all costs associated with the mailing.

3. One hundred percent paid by the carrier, with certain guarantees by the TPA and association. One such guarantee is that the case does not move within x number of years, and the administrator must have an agreement with the association that it will not move the case for x number of years.

The most common arrangement is cost sharing.

In a retention format whereby the carrier keeps a fixed percent of premium for expenses and profit, these promotional costs are initially fronted 100% by the carrier and then charged against the case balance.

Usually the association will not participate in the promotion costs. It feels it is supplying the name list, which has some economic value, free of charge to the carrier.

These promotion costs are amortized if we receive a guarantee from the TPA that the case will not move for x years, where x is at least one year but never greater than 10. If we cannot get a formal guarantee, we try for an informal guarantee so the costs can be amortized over at least six months. We may also have an agreement with the administrator that if the case moves before the costs have been fully amortized, then the administrator and sometimes the successor carrier must pay NALAC the amount of unamortized expense.

We typically amortize on a straight line basis. If experience is worse than expected in the first year, we may write costs down entirely at the end of the first year. We adjust after the first year depending on actual versus expected loss and lapse assumptions.

MR. VAUGHAN: I take the liberty of adding rate making -- both overall renewal rating and the internal rate structure that distributes the overall rates to member groups -- to the underwriting section.

UNDERWRITING AND RATING

There are many differences in rate making practices between large single employers and trade associations. At present, the greatest activity, the greatest change, and even some controversy, are taking place in the Medical area.

First, looking at the process of overall renewal rating, I'm not going to consider situations where a brand new Medical plan is being designed. In most cases, when you first encounter a trade association, it will not be one that has never had a plan. It will be one you are taking over, and you have some prior experience to go on. The number of such takeovers is rather small. In other words, there is not a lot of turnover from carrier to carrier in this business. Therefore, most rating activity will be rating existing cases of your own, occasionally rating an existing case on a takeover situation, and only very rarely trying to come up with manual rates for a new case.

There are several areas where the emphasis in the renewal rating process differs from that of large single employer plans.

The first area is the rapid change in exposure in trade association plans. It's quite common to have attractive rates for a period of time and to have considerable marketing success and plan growth. At the next renewal rating you'll find that your exposure is not centered in a 12 or 24 month experience period, but rather it is centered much closer to the end. On the other hand, the center of gravity of your experience period could move back toward the beginning of the period if you lose business because a rate increase was not accepted.

The second area is difficulty in establishing reserves. This relates to the changes in exposure, and I'll go into it in more detail in a moment.

The third area is the trend, when you look at an existing block of business. There's a tendency to try to separate the rate making for new business from the rate making for the existing pool of business. The reasoning is if you let existing pool rates seek their own level, the rates may not be competitive for new business. When you are rating an existing pool, you have to be aware of:

1. the adverse selection component of trend,

2. the mix of new versus renewal business that's anticipated, if this is not otherwise incorporated into the rate structure, and

3. the problems in adjusting past premiums to current rate levels. There may be several different rate levels during the experience period that came in force at different times for different groups. If you have quarterly rate adjustments with a 12-month guarantee, then at any point in time you have five different rates in force.

The fourth area is the difference in the appropriate retention charges, particularly the risk charge. The rest of the charges depend on how the work is subdivided between the administrator and the insurer. But the risk charges are entirely the insurer's responsibility and, because of the risk of adverse selection, probably need to be higher than the typical risk charge that might be used for a similarly sized single-employer group.

An important part of the renewal rating process is to establish reserves at the end of the period, compare them with the actual run-off of reserves from the beginning of the period, and come up with the increase in reserves to add to paid claims as an estimate of incurred claims. Because of the exposure changes, some of the formula reserving methods that are used for traditional group cases (such as using a certain percentage of recent premium, or a certain percentage of recent paid claims or a combination thereof) tend to break down. This even includes those methods that are adjusted for growth. Companies sometimes have a formula for converting paid claims to incurred that bypasses the setting of reserves at the beginning and the end but that attempts to take growth into account. Even such methods can be inaccurate, because growth tends not to be linear over the course of the period.

Incidentally, the lag between setting rates and putting them in force is about 2 to 2 1/2 months, and the experience you're dealing with is older than that. It is possible that you might be setting rates every six months, but only have an overlap of two or three months between the experience used and the last rate increase that was put into effect.

Since formula methods tend to break down, it's better to use a paid claim development method where development factors or lag factors are developed from company-wide experience. It's better yet, if the association is large enough, to use paid claim development methods where you actually develop the lag factors from the experience of that association, since there are differences in claim lag depending on the administrator, on the location, and on whether it's national or local in scope. There are definite distinctions from case to case in your claim reporting patterns and perhaps claim processing.

Paid claim development methods, where you simply take the claims emerged to date and multiply them by a factor to bring them to ultimate, tend to work very successfully in Group Medical for all but the most recent two months. The most recent two months have not yet emerged enough to produce a reliable prediction. The prediction may not be seriously biased, but it's going to be extremely volatile.

There are other reserving methods which attempt to make more stable reserve estimates by projecting "down" the months of incurral as well as "across" the months of development. One is known as the Bornhuetter-Ferguson method. A variation of this method, developed by Buehlmann, is called the "Cape Cod" method. These methods produce reasonable estimates of incurred claims for recent, immature periods, and they are fine, especially for setting year-end reserves when you can't wait for later information. But they work by projecting older experience forward to the more recent periods; they add only a little new information, so you shouldn't use them to shift your experience period closer to the present. If, for example, you had planned to use a 12 month experience period that ended in January, you have experience through March, you decide to use that experience and you have a reserving method that doesn't produce wild estimates of the most recent two months, fine. But don't use that to change to a 12 month experience period from April through March. You really haven't added much more information from the immature months of February and March. Instead just use the more stable reserving method to extend the experience period to 14 months. If seasonality is a consideration, it may still be better to use a 12-month period ending two months earlier.

If you're renewing a block of business that has been in force, there is going to be some additional trend in addition to the trend due to utilization, cost shifting, and changes in the Medical Care Component of the CPI. There is a difference because of the cumulative effect of adverse selection or the wearing off of underwriting selection, if you don't incorporate duration of experience into your rate structure in some way. At an open workshop session in New Orleans, someone from Bankers Life quoted figures it had developed which I think showed about a 3% differential in annual trend between MET business and large-single-employer business, which it attributed to this selection effect.

One other problem that arises in renewal rating is where you have a number of different Medical options. You have a portfolio of Medical plans, maybe Plans A, B, C, D and E, that differ from each other in deductible, coinsurance, out of pocket limit, cost containment features, etc. When the group is quite large there is a temptation to try to experience rate each of the plans separately. This can lead into all sorts of problems. You may have a plan which is doing well because you accidentally got a block of business in it that's much better than average. And yet it's relatively easy in most trade association plans for groups to move from one plan to another within the association. If your distribution system involves agents or sub-brokers, they will be very alert to which of your five plan options is the most competitive in relation to the market. If you have rated Plan B, let's say, on the basis of very favorable past experience with 100% credibility, you will find that you are going to have movement into that plan. At the next renewal, you will have lost money on it because the groups covered are no longer much better than average. So, it's probably much safer to use the plan relativities that have been developed in your manual rate structure and to renewal-rate the whole association on the basis of its aggregate experience, and keep the plans equally competitive. The other thing that happens is that the difference between, say, a $250 and a $500 deductible might get ridiculous, either too great or too small, such that people are practically forced to select or not select one of those deductibles. Sometimes associations do that intentionally, when they want to close out a plan.

The internal rate structure gets back to our analogy of trying to run a block of business in a small insurance company. You try to identify differences

among the buying units, the small employers, to the extent that the value of the information exceeds the cost. It's pretty easy to get useful information on a group basis from small employers. So there are a number of rating variables that can be incorporated at practically no cost, depending on your sales system. Whether they can be incorporated and not overly confuse the sales process is another question. Normally there's no subsidy available from the association to the small firm that's buying the coverage. Therefore you can't permit artificially equalized rates, that is, unless you have a very cohesive, high-affinity association. So, the situation is quite different from that of a large single employer, who can contribute enough of the cost so that a large percentage of the best risks will enroll, even though they pay the same as the worst risks.

There may be political considerations that push you toward levelling the rates. I think we've observed in the last two or three years that association executives are more and more willing to let the chips fall where they may and recognize differences in expected claims among the member groups. Traditionally, they were reluctant to use such differences as group size, industry, or area. But there is a growing tendency among association executives to be comfortable with these distinctions.

Age is, of course, a major rating variable. There are several ways of incorporating age as a rating variable for small groups. One of them, which is a technically inferior method, is to compute the average age, then enter a table of rates graded by age bracket, usually quinquennial, and come up with a rate for the whole group. Another method, the traditional method for larger groups, is to enter the age-graded rate table once at the beginning of the year; calculate an average rate for the group; and let that rate stick for one year or for six months, whatever the guarantee period is, regardless of changes in enrollment. And the third method, which I think is the most common now, is to look into your quinquennial rate table and charge the age-graded rate for each individual. The employer pays that rate each month and immediately adjusts the rate as he gains or loses employees. However, if the plan is contributory, the employer may choose to charge a uniform premium to his employees.

As for area rating, having been in a large insurance company at one time, I know that manual rate structures tend to be quite sophisticated. They look at just which components of the plan, be it surgical or whatever, vary by area. Then they actually work out a rate for each component and add the whole thing together. However, for small group rate making, and particularly for association plans which have to be sold conveniently, it's usually simpler to come up with an area factor that applies in a simple multiplicative way to the overall rate. In particular, if you're going to commit the rates to a small computer, it's easier to have a table of rates and then a table of factors, rather than ten different tables of rates.

As for dependent status as a rating variable, in the early days of Group Medical Insurance it was common for employers to use four or five classifications of dependents. Then, it was found that you could rely on averages, and it was sufficient for large employer groups just to use single employee and family rates. However, in the small group area and in the trade association area, we are finding that unless you use a more refined dependent status variable in your rating you will suffer competitive losses to those small group plans that are using it. Now it's much more common to have a four-rate basis -- employee only, employee and spouse, employee and child(ren), and all three. In fact, I think there may come a time when we have rates per child and rates per spouse, especially in situations where the employee may be obliged to provide coverage for two separate spouses because of court orders after a divorce.

Group size is another rating variable, sometimes objected to for political reasons by the trade association. The way in which we have seen group size used most commonly is with some cut-off, like 10 lives, above and below which the rates vary. On the other hand, it might be more practical to have a policy fee. Some plans do have something like that, although usually the fee is paid to the administrator, the premium is paid to the insurer and the two are kept separate.

Industry loading is not necessary when you have a homogeneous trade association, but has become a rating factor in Chambers of Commerce. Employer contribution percentage is a rating variable that attempts to pick up the potential

for adverse selection by individuals within the small groups, and does a pretty good job of it. I've seen it used in only one case, however. Employee participation percentage is usually an underwriting requirement, but may also be used as a rating variable.

The two most exciting rating variables at the present time are duration since purchase of the coverage and experience rating. Durational rating has, in recent years, been hidden in the rate structure of most trade associations in that there's a first year guarantee of 12 months, but the guarantee period for renewal rating is usually something less than that, like six months, or no guarantee at all. However, now we're beginning to see durational rating accomplished with an actual discount during the first year, explicitly recognizing that pre-existing condition limitations and underwriting selection make for better experience initially.

Experience rating is more complex. The question is, how much credibility in the general sense of the word can be given to the experience of a small group? The answer is, probably not very much. But, there is a strong political impulse in many associations to try to load the premiums of groups with poor experience. This is something that wouldn't have existed a few years ago, but now is commonplace. The associations are now willing to try to load the premiums onto those groups that are producing the losses if in so doing they can keep the new business rates reasonably competitive. You don't want to give too much credibility to the experience of a single small group or you wind up charging inadequate rates to "good" groups (groups with previously good experience). Nor do you want to give too little credibility. Of course, all along we have ignored experience as a rating variable, but there is probably some credibility that ought to be given to the experience of even a very small group. By ignoring it you wind up giving a break to the poor groups and losing money on them. The method that's used for experience rating is normally not the traditional larger group rate-making method where you give a credibility factor to the group based on its size and then apply that to its experience and blend it with the manual rate. Instead, the method that's been used by small employers or by trade associations is rate banding, in which rates are subdivided into five or six or whatever number of rate bands, maybe ten or even just two. And there are several rules for transition from one band to another

depending on recent experience. Usually the rules state that you don't move more than one band at a time. There's an implicit assumption of partial credibility in this kind of banding. We also see combinations of duration rating and experience rating used by some associations.

Experience rating of the experience before the group enters the trust is often used if the group is bigger than, say, 50 lives.

As far as actually underwriting, choosing what groups are eligible to come into your association, usually if the group is smaller than a certain size (typically six to ten employees), health questions are asked of each individual. If the group is larger than that size, coverage of pre-existing conditions is usually limited.

ADMINISTRATION

There are usually some account managers or administrative personnel both in the Broker/Administrator and in the Insurer who deal with any particular trust on a day-to-day basis. These people develop a wealth of expertise about the foibles of the market to which that particular trade association is selling. They know exactly what is needed in order to make the trust run smoothly. It is very important to take advantage of that expertise.

As for an actuarial interface from the administration system, there are some things we need in order to help with renewal rating and help pass judgment on the rate structure. We need to have good measurement of exposure. Ideally, the premium should relate back to the month earned. The premium paid each month often consists of some premium for that month, some premium for the previous month, and some adjustments that may go back two or three months before that. It's very useful if everything can be related back to the month in which it was earned, so that, after a lag of two or three months, we have an accurate earned premium figure for each previous month. This should be kept in rate structure detail so that, ideally, we can propose a new rate structure, plug it in against the exposure records of previous months and come up with what premium would have been generated.

We also need to have the claims by paid period versus incurred period, and ideally both of those periods should be just one month. Again, this is because the exposure may be changing rapidly. Systems in which the paid claims are simply subdivided by year of incurral or by the current year versus all previous years are not refined enough to help with reserving when the exposure is changing rapidly.

Another thing about premium administration is it may not be possible to force the member firms to adopt a neat premium accounting structure. We had a system in our company which was designed for a franchisee group, and the franchisee group really kept a tight rein on its members. When they were billed, they paid as billed, and any adjustments were made later. Any amounts reported but not matched to billed amounts were not entered into the system until they were matched. If the money came in correct a little while later, the system treated it as a reinstatement. It was very difficult to get good exposure measurements off of that system. It was good for the franchisee group, but when we applied it to the other groups it was hard to force them to adopt such a rigid approach.

The ideal administration system would provide the ability to measure empirical credibility -- in other words, to isolate groups in terms of the loss ratios that they experience during one period of time and then look at those same groups and see how their experience went in the next period.

CONCLUSION

There is one more difference between single employer groups and properly administered trade association groups (or professional associations, for that matter), and that is that associations tend to have better persistency with the carriers than single employer groups. The reason is that there is a price to be paid for changing carriers in terms of rocking the boat and shaking a few people out. And there's a trauma to the membership which you don't want to have happen. So there's a strong urge to remain with the same carrier and iron out differences rather than shop the case every year and jump around. So I hope I can persuade more of you underwriters to become involved in this kind of plan. That persistency is the reward you can look forward to.

UNDERWRITING

MR. CARLSON: We underwrite at three levels at NALAC -- the TPA, the case, and the individual members.

A. TPA Underwriting.

For a new administrator we call this an approval process, and for an established administrator you can think of our periodic audits as renewal underwriting.

1. What we look at most closely with a new administrator is the stability of its book of business. We check how long its business has been in force with the current carrier and what the history of that business has been. We do not wish to do business with a TPA that moves its cases around.

   Other items we look at are:

   How long the TPA has been in business. Most TPAs are former brokers that, after several years in the business, realize that the administrative part of its operation is more important than the brokerage part. As a result the older, more established TPAs may be better administrators than newer TPAs.

   Mix of current book of business. The TPA should have at least $1,000,000 of annual premium in force, and we can expect to write $500,000 of new premium over the next two years. We look to be a major player with the TPA, or else we may find our business twisted away from us at a later date by a carrier that has more influence with that TPA.

   The administration and claim operation and references from other carriers.

2. Audit.

   We perform general administration audits every 18 to 24 months on each TPA with at least $250,000 annual premium in force. We will audit more

frequently if problems develop. In a general administrative audit we look at new business processing, underwriting, handling of applications, issuing certificates, billing and collection, accounting, etc.

A claims audit is performed more frequently, typically every 12 months. We check to see that claims are being paid in accordance with the terms of the contract and the Administrative agreement with the TPA. Generally we can rely on the association to monitor the TPA's service to members.

B. Case Underwriting.

In most instances, we base our initial underwriting on the claims history of the case. If no history is available (i.e., an association which previously had no benefit program) we will underwrite the risk based on the experience of similar programs. If we have no similar programs upon which to base the rates, then the Actuary would assist in developing a pricing structure.

As I mentioned earlier, we are book underwriters. We require a source's total book of business to be profitable, not necessarily each case. We will take over a case in a loss situation if one of two conditions is met:

1. We get a commitment from the TPA to allow us to take corrective renewal action at the next renewal without moving the case.

2. If, for political reasons, the TPA must keep the case in a loss position, then our profits from its other business must offset losses on this particular case.

One important criterion we look at closely is the carrier history associated with each case. We are not interested in insuring any association that has a history of hopping from carrier to carrier every few years.

C. Individual Member Underwriting.

Underwriting of the individual member application is done either in the Home Office or the TPA's office, depending on the underwriting authority we give the

TPA. The amount of authority released depends on the TPA's track record and capacity. It may start with limited authority to approve all clean Life apps, up to say $50,000, but that authority would expand if, for example, it had a full-time underwriter on its staff.

We do very little guaranteed issue. The only case I am aware of is one Medical plan for members under the age of 40. Another exception is AD&D, where we do no individual underwriting.

Our simplified issue application is used when the amounts are not very high. It contains two questions and results in acceptance if both questions are answered no. If one question is answered yes, we decline and usually do not seek additional information. This simple process can be handled by clerical personnel in the TPA's office.

We use different applications on different cases. Some are long apps asking only Medical questions. We typically don't ask for financial information because the amounts are low, but will do so if the beneficiary designation is other than a family member. Then we would look for insurable interest.

Every app received in the Home Office has an MIB drawn. We do inspection reports only if needed, for example, if the MIB indicates a possible drug or alcohol problem. Generally we only accept standard risks, and we define standard as:

- Life -- up through Table 2 (50% extra mortality)
- Health -- up through 20% extra rating

D. AIDS.

First let me comment on what we are doing in our Individual Marketing and Reinsurance Divisions. We are in the process of changing our applications to ask specific questions about AIDS, ARC, and HTLV III antibodies and other immune system disorders. The Minnesota Insurance Department is making this a difficult task for us.

We are also requiring blood profiles at lower amounts than previously required. Each blood sample is tested for the AIDS (HTLV III) virus using the ELISA and Western Blot test. Where these are not allowed, the T-Cell ratio is tested for immune deficiency abnormalities. We decline all applications that we identify as having AIDS, ARC, or a blood test result compatible with a potential immune system disorder.

We have ceased writing Individual business in, and we will not accept any Reinsurance from, Washington, D.C., because of the restrictions there on our ability to act on such underwriting information.

In the association group area we currently have no questions on our applications for AIDS, blood disorders, or immune deficiency problems. We are looking into modifying our apps to include such questions, where allowed. We do carefully scrutinize each group's application, looking at things like:

- o amount of affinity in the group
- o geographical residence
- o occupation
- o type (term) and amount of insurance
- o manner in which the group was solicited
- o marital makeup

On one particular non-sponsored case, we do have an AIDS problem, and we are changing the app to include AIDS questions. We also require a blood profile on any application of $50,000 or more if no attending physician is listed as having been seen in the last five years.

On AIDS death claims we look at the application to see if any questions were answered fraudulently. However, on takeover cases where the former carrier did the underwriting, we would not have access to those applications.

ADMINISTRATION

We deal exclusively through TPAs, for reasons which I mentioned earlier. The duties which the TPA performs are as follows:

1. Solicit eligible members for enrollment.

2. Receive applications and forward to NALAC.

3. Issue certificates or individual policies to insureds, and deliver to the insureds or policyholders any other communications received from NALAC. As you can see, NALAC has no direct contact with the ultimate buyer. In fact, you have to look hard to find our company name on any promotional material.

4. Prepare and mail premium notices.

5. Collect and remit premiums (less administration allowances and commissions) to NALAC within 60 days from the due date. This includes responsibility for collecting delinquent premiums.

6. Maintain accounting, administrative, and statistical records.

7. Receive notification of claims, verify coverage and forward claims to NALAC for payment. Alternatively, some administrators may pay claims directly.

8. Handle correspondence and other general clerical and administrative functions, including maintaining files.

MR. FRANK J. ROBERTSON: Both discussions with respect to trade associations and individual associations indicated that the driving force is the Medical program. I was interested in the extent of the market you see for non-medical business sold to associations?

MR. CARLSON: I would take issue with that in terms of the professional associations where you're dealing with individual members, because there the driving force is typically Life, AD&D, or Disability products. The Medical products (i.e., Medicare Supplement, CHAMPUS supplement, Cancer, etc.) would be ancillary products to us.

MR. VAUGHAN: In the trade association area, the coverages that are going to be demanded by small employers are the coverages that large employers are offering, because they compete in the labor market, and that's the coverage they have to offer in order to compete. There are also some hybrid associations, that is, associations that are really professional associations but also insure the employees of the members, if the members have employees. Examples are associations of dentists or accountants. In that situation it could start out as a professional association plan, but it would be Medical coverage that they want. But other professional associations are very strong on Disability Income. They're also strong on Life, on Accidental Death, and on such coverages as Hospital Indemnity, and then they may have Medical in the form of an Excess Major Medical plan or Medicare Supplement or something of that nature. But Medical is not the driving force for the professional associations.

MR. ANTLIFF: Incidentally, a lot of these associations are involved in Casualty coverages, and apparently something happened during the hard market of the mid and late 1970s wherein Commercial Liability and Professional Liability had a big increase through the association distribution system. Dick, with your knowledge of the Casualty side, has that been happening in the last three years when the hard market returned?

MR. VAUGHAN: Well, I think it has to some extent. I can't quote statistics. Often in the Casualty area when the term association insurance is mentioned, the reference is to associations of really quite large employers who banded together by forming captives to obtain coverage that they otherwise couldn't obtain. And, in the case of associations of small employers, I think that yes, there is movement in the Property and Liability areas. I've seen recent cases where associations are exploring offering Professional Liability that didn't offer it before. And the hard market is impacting associations also in the negative sense: the market is even harder for an association, because the insurer is a little concerned with the risk of adverse selection within the association. So both of those things are happening. Whether there is an increase in the number of new plans being offered by associations in the last year or so because the market is tightening up, I don't know.

MR. ANTLIFF: The NAIC adopted the administrators' model bill about eight or nine years ago. Presumably there were perceived abuses 12 years ago that led to the adoption of this model bill. The bill has been in effect for more than five years and is approved in 22 states. Has there been a beneficial effect? Has it had any effect?

MR. CARLSON: John, I'm not aware of what has happened over the last five years with that law. All that I can comment on is that our agreements with our administrators do conform with the statute.

MR. VAUGHAN: I can only say the same thing. I'm not familiar with the details of the law. I know that our legal department has been very careful in structuring agreements with insurers to be in compliance with any such laws.

MS. BETSY K. UZZELL: Mr. Vaughan, you commented about possibly needing lower rates than theoretically correct rates to attract new business. With regard to Life, particularly for individual members, have you seen success in attracting new members by lowering rates at lower ages and raising rates at higher ages?

MR. VAUGHAN: In at least one professional association case we had a situation where the Life loss ratio analyzed by age group showed a distinct deterioration around age 50. In other words, the older ages had been given somewhat of a break in the rate making, and I think that once that was substantiated, an effort was taken to correct it. But I can't think of any cases in which an overt attempt has been made to artificially subsidize the participation of the younger members (because once they're in, they tend to stay in) by setting their rates lower than what would otherwise be indicated. However, there are accidental differences in the steepness of the rate scale that come about because these rates were often adopted many years ago, and the steepness of the scale may get out of kilter after a period of time. One thing that does work in favor of the younger ages is that expenses are often loaded in simply as a percentage of the rate, and that tends to charge an excessive share of the expenses to the older members and an inadequate share to the younger members, which tends to keep the rates at young ages a little more competitive than they should be.

MR. THOMAS BIERLEY: We tend to shy away from associations, and I think it's because we feel there's no one decision maker. You have member employers each deciding independently whether to get coverage or leave the group. We feel that it's necessary but almost impossible to get a real strong endorsement from the association. Do you have those same concerns, and are there techniques in getting the kind of endorsement from the association so that the member employers or individuals feel a strong desire to participate?

MR. VAUGHAN: I think you're quite right. One of the big reasons for the success of any association plan will be the strength of the endorsement. That substitutes for what otherwise might be a difficult marketing effort. In other words, it gives an entree, it makes the response rate greater if you're using direct mail and it makes the work of the person going out and soliciting face-to-face easier. That's the value of sponsorship. A strong endorsement reduces the long term cost of coverage because the marketing is that much easier. We urge the association to give its plan a strong endorsement -- to give it the best chance of successful growth.

MR. ANTLIFF: Association Group is a vital force. It deserves to succeed because it's good for all the parties. It's good for the associations, for the employers in employer associations, for the insured individuals, and for the insurers because it is profitable and has good persistency. You can obtain additional information on this subject from at least two sources. The TPAs have a trade association called PIMA, which is the Professional Insurance Mass Marketing Association, and the associations have a super-association, namely, the American Society of Association Executives. Because this market requires personal attention by the insurer at a decision making level, it's not uncommon for big organizations to have a spotty track record. There's plenty of opportunity here for smaller carriers to make inroads into an attractive market. There's room for innovation, but basically the game plan has to be quality products and services at a reasonable price, good service to claimants and above all the personal touch in meeting the needs of the association.