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MULTIPLE EMPLOYER TRUST ISSUES

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- o Renewal underwriting
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MR. RICHARD BILISOLY: I'm a group actuary with the Wyatt Company in Chicago, and I would like to introduce our panelists. Mr. Constantine "Gus" Costas, C.L.U., is vice-president and an officer of five of the affiliates of a consortium of insurance companies known as AEGON USA, formerly Life Investors Insurance Company of America. Recently he has been the vice-president in charge of general underwriting and administration for multiple employer trusts (METS) for AEGON. They have some large blocks of MET business and managed to stay afloat for a number of years.

Mr. Ted Garrison, FSA, has been, since 1985, senior vice-president and chief financial officer of an organization known as Starmark, a marketing subsidiary of the Benefit Trust Life Insurance Company. In that capacity he has been working exclusively with small groups such as METS.

I would like to give thanks to Barbara Niehus (FSA) and to other authors of a very new study note, *Financial Management of Small Group Health Insurance.* I commend it to your attention if you want to learn more about METS.

CHARACTERISTICS OF SMALL GROUPS

Let's start with just a very brief outline of some of the characteristics of METS. These small groups encompass a very large proportion of employees in the United States. If you take all firms with 25, or 20, or fewer employees, you're looking at maybe a third of the entire working population. As such, it is an important subject to address from the standpoint of marketing and sales. As a consultant, I have had occasional exposure to METS, and it is often exceptionally difficult to manage, underwrite, and oversee the financial management of these small groups for reasons that our panelists will discuss. There is a high turnover rate among the insured groups, and a high failure rate. I hate to call it a failure rate because the entire insurance company may not fail as a result of its failed MET business. However, it may be forced to get out of that business in time, and, indeed, in talking to some of you who have been heavily immersed in the MET business for the last several years, I have heard that there are about 30 large organizations which, in the last year, got out of the MET business due to the difficulty of managing and underwriting those groups. It is a very competitive business; much more so than a large group because of the opportunities for selection by the small businesses which buy this insurance.

What are some of the characteristics of the small groups that make them so difficult to underwrite? First of all, among the small businesses themselves, there is a high degree of failure simply because many of them are new and have recently started. They are not as prepared, perhaps, to meet the vicissitudes of the market as are larger companies. Due to that fact alone, there is a larger turnover in that kind of business.

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A larger failure rate means lapse rates are higher as an insurer. There are higher expenses associated with this business, not only because the groups are smaller (spreading the expenses only a smaller base), but because of other activities. Many of these groups are extremely small, three to five people, and may consist of only the family-owned business. Gus Costas will elaborate on this point.

MR. CONSTANTINE T. COSTAS: One of the key areas in METS that leads to a lot of the frustrations that people have in dealing with the administration of a MET. The small employer perceives the group health program first and foremost as his or her personal benefit. As a result of that, the enforcement of the eligibility requirements and ongoing requirements to maintain coverage in force are easily manipulated. That leads to excessive claims and excessive costs resulting from regulatory authorities and from complaints and litigation. Anybody who is not in this business and is planning to get in should have an underwriter with a backbone of iron who tells the marketing people exactly what risks they will and will not accept. The important to enforce these participation and eligibility requirements consistently and thoroughly, and make no exceptions.

MR. BILISOLY: Individual evidence of insurability is often used. When I first started out in group business many years ago someone said, "Beware of hospital employees, morticians, and undertakers." These were the high-hazard industries, but in the small group business, the individual underwriting largely alleviates worries that might otherwise arise from these kinds of businesses.

One final characteristic in small groups is the difference in the rate sets that you might see. Let me illustrate this with a short example. One trust may have quinquennial age bands that run 35-40, 40-45, 45-50, and so forth, whereas a competitor's trust trying to lure away its business may have age bands of 30-40, 40-50, and so forth. If you have a 34-year-old who sees in the quinquennial age rating that he is just about to be moved into a higher rate band, he may be tempted to jump into your competitor's trust which holds the rate for his age steady until age 39 or 40.

SALES METHODS

In order to plunge more immediately into the real substance of our discussion, I would like to move on to sales of METS. This is such an important topic that I would like to ask our panelists how they go about acquiring new business in their companies and which of these methods seem to be most effective. Gus and Ted, would you care to comment on which of these methods you deem to be most effective in terms of cost as well as the ability to garner new insureds?

MR. COSTAS: In our operation we use a third-party administrator (TPA) approach. We have found that, from our perspective, this is the most economical approach since we know what our fixed sales expense is, and we do not have to deal with the recruiting and training of a field force. We permit the TPAs to use any method they wish as long as it is within regulations and complies with all the state's requirements. I will say that one of the problems inherent in the use of agents, as opposed to some other approaches, occurs when you are in a multi-tiered marketing system. There is a dilution of the expertise at the point of sale which can lead to some of the service problems and administrative problems that I alluded to initially. You have to have a pretty good handle on how this dilution occurs and how these tiers operate in order to provide some comfort level at the point of sale so that the person actually getting the application is accountable to someone else. That way, you can maintain some sort of control over what is being said, how it is being said, and what is perceived by the applicant. However, I will say that, due to the perceived complexity of the product by the person or persons making the purchase, those that are sold by agents are by far the most successful. So, it's a two-edged sword. You need a good field force to sell any meaningful quantity of this. On the other hand, you have to control that field force so that the material being provided at the point of sale and what is being said reasonably describes the product and that it will not offer more than it is designed to offer.

MR. THEODORE W. GARRISON: My company primarily uses general agents, although we have contracted with a couple of other companies for use of their field force. One characteristic that is very important and frequently missing is loyalty on the part of the agents or loyalty on the part of the field force where they will, indeed, make a good faith effort to sell your renewal rates and where they will, in fact, try to bring to you all of their business or what they consider to be good business. The alternative is agents who will have a primary outlet, elsewhere and will bring you only those groups which were rejected by their primary outlet, or the price mongers who are

looking strictly for the lowest price. If you make a mistake with your area factors and, indeed, are the low quote in a particular area, they will load you up on that. When you subsequently get wise and raise your area factor and start to renew these groups at slightly higher rates, the agents will again yank the business and go looking for the lowest cost that is then available.

Working with general agents, of course, we have run into both kinds: some very good ones and some that are not as good. We have run into some that have a great deal of loyalty and others with less. We have had some that have gone into telemarketing of sorts; that is, general agents who spend their time on the phone. We have had agents who hired people to spend their time on the phone calling agents, trying to round up agents to peddle their product, and we have others that have actually hired telemarketing people to sit and call up prospective customers to call up employers. I don't know that either of these kinds of operations have been greatly successful, although they have produced business for us.

MR. BILISOLY: I would like to make one remark about sales that I noticed in my work with METS. I was surprised at the disparity in costs of each of the two methods of sales used, and yet both were fairly successful. One organization that I worked with was a fairly large banking association, and they effected most of their sales through a TPA, a professional administrator who paid claims and yet who devoted a lot of energies to sales. I believe the proportion of premium consumed in getting new business was no more than 2.5-3.5% of the total premium, and the sales were accomplished mainly by mail order. There were very intensive efforts on mailings, followed by group meetings whenever the banking officials would get together. They would be regaled by a group salesman with a pitch on the insurance. The participation was pretty good in that association. That was an association as opposed to a MET.

In other instances I have seen cases where as much as 20-25% of the premium would be expended merely to compensate individual salesmen. There was a large, individual sales force. Here you are using a fourth of your total premium just for compensating the salesmen. In those cases a fairly high participation was obtained. Now, I suppose it is a very different kind of business, and perhaps there were good reasons for using each of the two methods, and yet I realize that there is a whole spectrum of methods of sale in between. I wonder if the panel has any insights or any comments on that big disparity in the proportion of premium used to achieve sales.

MR. COSTAS: Obviously in the affinity group, such as the banking operation, you do borrow the prestige of the organization recommending it. That helps open the door; sales costs should, indeed, be less. Rates in that type of group should be less overall simply because it is easier to sell. There is a certain affinity there. With respect to the general marketplace, I do not think it is any different than Insurer A going after Insurer B or Insurer C going after anybody else. Every agent is out there selling one, two, or three different trusts he has in his briefcase, and there may be another agent with another half a dozen. So, the competition is fierce. And if you are in the agent market, the general market, you can expect that commission rates have to be at a certain level. I do think, however, as these rates keep going up our industry is going to force us out of some of the marketplace by virtue of the fact that the small employers just will not be able to afford the coverage, period. Rates are going to have to reflect lowering of commissions as time goes on. In my opinion, at least, it is awfully difficult to be able to justify a level commission rate today on a premium that is 100% higher than it was 24 months ago for the agent who has done essentially the same work, in theory. The industry is going to have to come to grips with that. That is awfully hard to explain. Nobody really wants to be first. Somewhere along the line I think it is going to come. If a hearing at the federal level were to come against the health industry, I think that it would be pretty hard to explain why 20% or 25% of a small employer's rates were in commissions, where the rates are double what they were just a couple of years ago. I am being a little redundant, but I think our industry is going to have to face in the near future.

MR. BILISOLY: There are many factors that are important in the writing of this MET business, but, nonetheless, rates are one of the most important. It is more incumbent upon us as actuaries to have correct rates for all the cells in the matrix of premium rates for small groups, than it is for large groups because of selection problems.

MR. GARRISON: It is incumbent upon us to have fairly sophisticated rate scales. The problem is that it is difficult to have one cell subsidizing another cell or one group subsidizing another group. If you tried to charge flat rates for all groups, regardless of whether people were young or old, obviously the young people would go somewhere else where their lower claim cost was

recognized, and the older people would flock to you, and whatever rate you had would soon be inadequate. Most companies end up with a rate scale with age-specific rates and general quinquennial age bands. Most companies use sex-specific rates, although Massachusetts and Montana, at least, require unisex rates, and some companies do use unisex rates nationwide. With respect to the rates for dependents in big group rate structures, the most common thing is to have a single composite dependent rate which applies regardless of whether it is a spouse only, or a child only, or a spouse with several children. But in small groups, it is more common to have one rate for the spouse and another rate for children. Some companies even have a rate per child, providing further sensitivity. A few companies vary the rates by smoker status; a discount for nonsmokers. The marketplace is highly competitive, so we see more distinctions in this area in the future.

I spoke a little while ago about the need for loyalty of agents, agents that will bring you their good cases and agents that will not necessarily go shopping for the lowest possible available rate. Even with the most loyal of agents, loyalty can only go so far. If your rates are not competitive, you are going to have difficulty getting new business regardless of how loyal your agents are.

For the length of rate guarantees, a company may offer a 12-month rate guarantee or a 6-month rate guarantee. Take your choice for the rate differential. For a few companies, those same guarantees are offered on renewal business as well as on new business. These companies are definitely an exception. There are not very many companies that will offer 12-month rate guarantees on renewal. Most companies in their renewal years just put the contracts or the business on a monthly basis where the rates can be changed on any premium due date. Other companies follow the practice of changing the rate for the trust periodically without any particular guarantee, but every 6 or 12 months they will change the rates for the trust and increase the rates for everyone in the trust at the same time.

We have already touched on the high cost of commissions which are generally remaining at the same percentages they were a couple of years ago when premium rates were half of what they are now. In effect, the agents have had a 100% pay raise in the past year or so. There is a wide range of different possible levels of underwriting.

PREMIUMS

One unique characteristic of a small group is that, because of the underwriting, and most companies do a fairly thorough job of underwriting, there is a select and ultimate claim pattern (referred to as the aging curve) where, in the first year, the claim costs will be relatively low because people have just passed through the underwriting process and are all healthy. Also in the first year, the preexisting conditions provisions of your contract are in effect, holding down the claim costs. After the first year, people are getting further and further away from the underwriting, and your contractual protections run out; the claim costs will tend to start increasing. In setting your initial premium rates you certainly have to recognize this aging curve and have a strategy for dealing with it.

The competitiveness of the marketplace generally requires companies to charge rates in the first year that are adequate to cover first-year claims and expenses. If, indeed, they do that, then when the second year comes, the companies need to again recognize the aging curve and the fact that their claims will be increasing, not only because of inflation, but because of the wearing off of the effects of underwriting and the expiration of the preexisting condition limitation. Compounding this is the fact that, in small groups, there are fairly high lapse rates, generally greater than for large groups. These lapse rates can come about because of small business failures and the desire to change carriers for resisting the rate increases. Necessary rate increases, increases to not only cover inflation but to cover the higher renewal claim costs, can be quite large, and tend to drive the business off the books. If you get too many terminations, you get into an experience spiral where the more you charge, the more the good groups leave you; and, as the good groups leave you, the quality of the remaining business is worse and the average claim cost is higher. You can head straight down the tube in this experience spiral, or death spiral.

I do have one comment I would like to make on initial premium rates. One of the things we have seen in some of our blocks with rates being raised so dramatically is a large influx of groups of 30 to 40 lives trying to come into our trusts. There was a point in time that the MET rates were actually lower than the true group contract rates, and it is perceived by the agent to be a temporary parking place he can move this group into until he can find something a little more competitive. That is a danger. It is a danger in this respect: the agent is making a level

commission on a much larger premium than he would otherwise make if it were a traditional true group approach. More importantly, if that particular group is a bad group from a claim standpoint, it is going to adversely impact the rates on the smaller groups when you rate the entire trust. You then give the entire trust a rate increase. That group is large enough to leave and go somewhere else because it can get its own contract somewhere, and now you have the remaining better groups that are catching up the losses that large group created.

Conversely, if the large group is a very good group and costs you very little claims, but is a significant percentage of the premium, and the remaining groups are small with experience that is worse, and you raise the rates, again the large group is going to run. So, as a rule of thumb, groups of more than 15 lives really should not be in a MET if you want to have consistent, proper rating. If you have too many large groups, you should design a MET to have a minimum and try to stay within the lives category.

MR. BILISOLY: Ted, if you held all factors the same -- age, geographic location, sex, and so forth -- except for smoker status, what would be the differential in the rate percentagewise between smokers and nonsmokers?

MR. GARRISON: We're using our rate scale, for better or worse. For life insurance we give a 40% discount to nonsmokers. So, our rates for smokers are relatively high, but then the discount rate brings our rates for nonsmokers down to a very competitive level. We arrived at a 40% discount by reading the *Transactions* and some of the studies of State Mutual and others. The published material led us to that discount factor. For disability income we are giving a 20% discount. For medical care we are giving a 10% discount. Frankly, I do not have good statistics to support either of these. I have the personal conviction that the value on medical care is a lot more than 10%, but, on the other hand, because the dollars involved are so large, I am a little reluctant to give a very large discount. One reason for this reluctance is the lack of control or lack of enforceability. We just ask, "Have you smoked a cigarette in the past? Are you a smoker? Have you smoked one or more cigarettes in the past year? Yes or no." We take them at their word. It would be easy for them to misrepresent themselves and so difficult for us to enforce it that I just do not like the thought of putting a much larger incentive to untruth out there than what we have.

MR. BILISOLY: To bring home the true effect of the aging curve and select and ultimate morbidity, could the panel give estimates of the difference in pure morbidity cost on medical between two groups that are the very same in all respects -- age, geography and so forth and so on -- except that one is in its first year, and one has renewed into the third or fourth year?

MR. COSTAS: It depends on what the original plan design of the group was to start with. We have seen that groups in their first year that have a preexisting benefit allowance of some amount will have a much higher claims cost in the second year than a group that had no preexisting benefit allowance.

For example, you take over a ten-life group and provide a $2,500 preexisting benefit allowance. Well, if you find that you're paying out the full $2,500 allowable on any one condition in that group, then that condition is going to cost you quite a bit of money in the second year, especially if it is an elective condition. Now, take the same set of circumstances where there is no preexisting benefit allowance. A person in that group may resist going to the physician until the beginning of the second year and may not incur the claims until the end of the second year; and then in the third year, you are going to get clobbered. People are smart. They know what they can spend. Doctors are masters at scheduling surgery on the 366th day of coverage, especially if they can get paid for tests that need to be done during that first 12 months. If there is nothing there to pay for it, they defer everything. I would say that, in my opinion, you can anticipate about 25-35% increased morbidity cost third year over first year and so forth, and that is significant.

MR. GARRISON: It is not a simple question to answer. For one thing, we do underwrite new entrants to the group. So, people who have come in and entered the group near the end of the first year or going into the second year are themselves freshly underwritten. So, you do not have a clean block of business that was all underwritten one year ago, comparing the first-year versus second-year experience on that.

Another complication to the model is terminations. Business failures may not be particular as to whether they happen to healthy people or unhealthy people, but other kinds of terminations are definitely biased in the direction that the sick people are not very likely to leave you, and the well people will, on occasion, jump ship and find a better deal somewhere else. So, in the second year, you will have lost some of your better groups, but you will still have all the bad ones. You have conflicting forces.

One thing that can be used in conjunction with the preexisting conditions exclusion in the contract concerns larger groups. The larger groups will be taken on what is sometimes referred to as a no-gain, no-loss basis. With respect to preexisting conditions, they will be paid the lesser of the benefits provided by the contract and the benefits provided by the prior carrier's contract which is being replaced. This feature in itself, as opposed to providing no benefits for pre existing conditions, is probably worth at least 10% in the premium rate, and that does not take into account the deterioration in underwriting.

MR. COSTAS: I would like to add one more point, piggybacking on something that Ted said about new lives. You have new groups coming in, but I think just as important is the problem of monitoring the participation requirements in the existing groups. Let's take a five-life group, and assume that your average life count per participant is five lives. If we get the normal spread, we are going to have one person that is going to have some health problems. You are going to get three average people. And you should get one very healthy person in that group of five. If that fifth person drops off from the group, you are getting adverse selection within the remaining four. What kind of job is being done to monitor the fact that if that fifth person dropped off, was he or she replaced by another person or did that person drop off simply because he or she did not want to pay the premium? Or was that fifth person the one that made the case eligible for guarantee issue in the first place? All of these things, I think, also lead to some of this wearing off in this additional rate that is needed. So, it is not only new groups, but it is the turnover of lives within the existing groups that have to be well monitored to make it work.

MR. GARRISON: With respect to monitoring participation, there is even a worse scenario situation than having that fifth life drop off, and that is where, in the renewal situation, you start out with a six- or eight-life group, it shrinks down to about two or three lives, and those just happen to be the sick ones. The other five people that were previously insured have gone and gotten themselves some cheap coverage somewhere else; they completely bailed out and changed carriers. They have a new plan, but they left the sick lives with the old plan. I think this is a real potential threat. It really does happen sometimes. So, it is necessary to watch for changes in in-force, especially where what is left is the unhealthy person, and try to police it by working through the agent, or with the employer directly, or require some employment records to verify that you do, indeed, still have your minimum participation requirement. I think most contracts do have minimum participation requirements, often about 75%. I am aware of at least one major carrier that does not have participation requirements, but I feel that is a mistake. Participation requirements are really important for a reason: it gives you a legitimate out for cancelling this case in the situation where the good, healthy lives have changed carriers and left you with the unhealthy lives.

MR. COSTAS: That is in violation of the contract, and coverage is terminated. That leads to other problems. You are going to get a letter from a lawyer saying, "How dare you do this!" Remember, I told you it is perceived by the small employer that it is his personal product. It is an individual policy as he or she looks at it. "You cannot take this away from me. I am not subject to participation requirements because I am the owner. I work a hundred hours a week. I could be lying in my hospital bed and running my business by telephone." It really gets ludicrous, but those things happen in this business.

MR. BILISOLY: Let's go on to renewal rating strategy. Ted, I wonder if you would lead off and explain to us what some of these terms are.

MR. GARRISON: We have already discussed the classic MET dilemma, the dilemma created by the aging curve, by the competitiveness of the marketplace which almost requires you to have your first year rates down at a level consistent with first year claims and expenses; and then the aging curve takes over and the terminations then come in. There is always this potential risk of getting into the adverse experience spiral or the death spiral. It is very difficult to turn around a sick trust. When a trust gets in sufficiently bad shape, it may be necessary just to cancel the

whole trust. Several insurance companies have just gone out of the business. They found that they had something they could not handle. They have gone out of the MET business and tried to sell their trust to someone else. If they could not find a buyer, they just terminated the business.

Once the trust is in bad enough shape, across-the-board rate increases are not likely to succeed. A 50% increase in rates in this trust may be required. With that substantial a rate increase, the good groups will leave. The claims will hardly drop, and possibly the total premium in force after the terminations have happened will not have increased much. The trust will be in just about as bad a shape as it was to begin with. Therefore, it is very important to have a renewal strategy to deal with this dilemma. As an actuary going into the business, a model must be established that includes a renewal strategy. For each generation, or cohort, of policies that are issued or of employers that are covered, there should be a plan where that cohort of business, say all the employers written during a three-month period or during a year, will, over its lifetime, produce profits. Maybe the model will call for higher profits in the first year and hopefully try to attain a break-even performance after the first year or maybe after the second or third year. One way or another, there must be a plan for getting enough premium from the trust to cover all the claims and expenses with the desired profit objective left over. What follows are some of the alternative strategies that are available.

First, a scale of uniform rates which apply to all new and renewal business may be used. This was the typical way the business was run up until recent years. It is rare to use this practice. I am aware of one major life company that had their trust on this basis, but they closed down their trust and stopped accepting new business and were looking for a buyer for the trust just a few months ago. The problem is that to have one rate that is adequate clear across the board for all new and renewal business means that your new business rates are fairly high; and with fairly high new business rates you are not likely to get the new business. And when you do not get the new business to support the older business in the trust, then even that rate level is not adequate, so the rates need to be raised even more. That may completely shut off the new business.

The second strategy is durational rating. You see the aging curve. The average claim cost is going to be higher in the second year than in the first, and higher yet in the third year. So, the rates are set accordingly. Quite a few companies use durational rating. Most companies use at least a modification of durational rating where the cases coming up for renewal are not renewed at the same level as new business. Of course, the same old problem develops here. If the second year rates are 25% or 30% or 40% higher than the new business rates, there is such a heavy distinction that better groups are going to realize fairly quickly that they can get a better deal somewhere else. Therefore, they will jump ship, and then even those rates are not going to be adequate for the worse cases that remain. Therefore, it is necessary to somehow not hit the good groups quite so hard. It is important not to drive the good groups off the books by charging rates that may be necessary to cover the claims on the bad groups.

The third strategy is durational rating with reentry underwriting. Several companies have tried this recently where the second year rates may be at a relatively high level except that the company will invite the renewing groups to submit new applications with the thought that the good groups are going to go shopping anyway. So, instead of having them shop elsewhere, they shop with the original company. They will be reunderwritten and reentered at the new business rate scale, possibly even with a new preexisting condition language applying. My understanding is that this strategy has not worked very well. When you send out an invitation for reentry underwriting, many employers will not only submit their application to you but will submit it to your competitors as well, so you still have a lot of terminations. The better groups will end up going elsewhere.

The final strategy is the concept of tiered rating, and it is this strategy that most companies now are using in some form. Some way or another it is necessary to differentiate between the good groups and the bad groups prospectively and be somewhat more lenient on the good groups. There should not be overleniency on the good groups because then the bad groups are going to be losers. There is no point in segregating off all the good groups and treating them as new business, charging new business rates for them. The remaining bad groups will have some bad risk. Trying to make them a self-supporting pool unto themselves will be difficult because, by the time you have peeled out all the good ones, the bad ones will be sufficiently bad and it is very difficult to get an adequate rate for them. It is important to end up with some kind of a compromise where the rating is not being overly hard on the good groups, yet not overly lenient either. Some

subsidization will occur from the good groups to the bad groups. The objective of renewal rate setting, of course, is to get adequate rates for the future. If a particular group had very high claim costs, but the person that caused the claims has terminated or died, at that point what is left might be just as good as another group. Certainly, there is no point in trying to recover the past losses in this group marketplace. That does not make any sense at all. The renewal objective is to set prospective rates that are adequate. So, if possible, review or take into account whether the people who caused the claims are still actively insured in the group or not. It is possible, perhaps, to see that the claim was an accident that occurred several months ago, and there have been no charges since, or maybe the cause was a normal maternity. These kind of claims have no implication for the future, and again the group perhaps is completely standard or, better still, is one of the good groups, even though it produced a loss for the prior year.

On the other hand, if there is a really big ongoing claim, then there is an ethical question that just cannot be disregarded -- the ethical question being the fairness of raising rates on these sick people. They came for coverage and were underwritten. They were healthy when they came in the door. They bought this insurance in the event they got sick, and now that they are sick, the rates are being tripled or even cancelled. That does not ring very well. I feel that we, the insurance industry, really have a moral responsibility to continue insurance on these sick people at some kind of a reasonable rate and not force cancellation or price them completely out of the market. In looking at groups at renewal time we have run into situations where maybe it is a four- or five-life group, and every one of the employees has got $1,000 worth of claims in there. There does not appear to be any serious diagnosis. You are losing money on that group. I do not personally see any ethical problem in raising rates on a group of this nature. But when you run into the really sick people, then we do have a responsibility to continue insurance on these people at some kind of an affordable rate.

Looking at the larger small group area, the 10-, 20-, or 50-life groups, it is common practice in setting renewal rates for those kinds of groups to take the experience of the group into account and to charge more for the groups that have bad experience. An analogy coming down into the baby group market would be that there are none of the ethical problems discussed earlier with respect to charging a moderate amount more for the groups that have unhealthy people in them. If these same unhealthy people were on a 25-life group where you were giving some limited credibility to the experience of the group, the group would end up paying a higher premium. It seems reasonable, in like manner, to charge at least a moderately higher premium for the baby group that has the sick people in it. It is tough for the small employer to cover the rate increases. And, of course, from our point of view, it is tough for us to try and stay in business. Of course, we recommend plan changes or other devices. A change to a less expensive plan is the primary device to cut costs. I have a great deal of sympathy for these small employers. It is really tough on them, and it is tough on us to have to try and foist on them these 30%, 40%, and 50% rate increases that have been so common over the past year.

UNDERWRITING

MR. BILISOLY: Let's turn now to the subject of initial underwriting.

MR. COSTAS: I would like to lead off by asking a question. What is medical underwriting worth as opposed to guaranteed issue? It is the difference between staying in the MET business or not. In other words, the risk selection process, hopefully, will help get good, solid insureds producing a reasonable initial rate. Initial underwriting might play out in the second, third, or fourth year down the road due to the lingering effects of the risk selection process.

From an initial underwriting point of view, if you had 11 applications in a group, 11 employees, and it covered a population of 30 individuals with dependents, and there was not one question answered, "Yes, I have seen a doctor in the last five years," what would the underwriter do with that application?

MR. JONATHAN ROSENBLITH: I think there are really two answers. I cannot answer it just in terms of a rate. We had a situation where, in the state where we originally established the trust, we could not ask medical questions, and were losing $1 million. We came to the conclusion that we could not stay in that business without asking medical questions. We then moved the trust to a state where we could ask medical questions, and found that the rates that would be competitive with the marketplace would then generate at least a break-even return; in fact, we have made a profit for the last four years. It has not been a very large profit, but I am really happy that we

have made any money in it, and we can stay in business on that basis. So, I think it's been 30% or 40% as far as the rates are concerned. My question is, can you come up with any kind of a reasonable rate at all?

MR. COSTAS: The point I am trying to drive home here is it is not so much what the rate differential is, in my opinion, that makes a plan successful or not successful. Guaranteed issue, if handled properly, with the proper contractual protection, can be profitable, but you need strong, consistent underwriting. You have got to know when to say no. Now, using the example I gave earlier, you have an 11-life group applying, and there are 33 people in this population for these 11 employees, and not one question is answered, "Yes, I have seen a doctor." Is that a better group than a guaranteed issue group?

MR. ROSENBLITH: Yes, because we can rescind coverage if they lied or if they were inaccurate.

MR. COSTAS: In a guaranteed issue concept where (1) you have a good, strong preexisting limitation, (2) you really enforce the qualification of effective date provision on dependents, (3) you ask questions on your application, and (4) follow up that employer application with the proper telephone interview by the administrator of the plan, the case may not be any worse than the 11-life case where everyone answered, "No." We are finding it is becoming more and more difficult to effectuate a rescission in certain states because of the changing legal climate, and every time you try to effectuate a rescission you get a lawsuit. What does it cost you in litigation expenses even if you are successful? So, this whole question of medical questionnaire versus guaranteed issue and such is really academic. In my opinion, it is the strength of the people doing the underwriting. You, as actuaries, can design anything based on certain assumptions. If those assumptions are not carried out, however, it does not make one iota of difference what rate you charge. It is going to be a loser. So, the people must be strong who tell the agent in either a very nice way, in a medium tone, or in a very gruff tone, if necessary, "I don't want this piece of business."

In order to succeed in this business I think you have to have people doing these dirty jobs, doing them well, and doing them very consistently and in accordance with the contract, and not deviating one way or another. That is the only way you will be successful. Now, if you do that, be it guaranteed issue or medically underwritten, then tell me what the rate differential is, and I will buy it.

MR. ROSENBLITH: I agree with what you said. It hinges on the underwriters and how good they are and how much they can stick to the standards; and that is going to make the difference ultimately. However, I feel very strongly from my own experience that the medical underwriting questions give them an additional, necessary tool that, along with their talent, can make a difference.

MR. COSTAS: Yes, absolutely! I agree with that wholeheartedly. And the medical questionnaire has a sentinel effect. You may not get the bad group to start with.

MR. ROSENBLITH: The employer in a guaranteed issue situation may not know about some condition that the employee does know about.

MR. COSTAS: Absolutely true! But that is also true for a medically underwritten case. Let's talk about a medically underwritten case where the employee says, "Well, I have a child here that has a condition but has not seen a doctor in six months. So, I will just say there is no problem." The employer does not know about it. Six months later that condition turns into a serious situation. First, the employer gets concerned because he feels he is looking down the barrel of a gun and might get a big rate increase. Second, that employee is concerned that there may or may not be coverage once an investigation is overturned. Then you have the third concern that might arise if the employer gets upset. Now, we are talking about the small employer market where they are not aware of Equal Employment Opportunity Commission (EEOC) rules. The plumber has got six or seven employees and no bookkeeper, and no personnel manager out there. All that plumber is worried about is, "I would rather get rid of this guy and get him off my payroll because he and his family are going to cause me problems."

Unfortunately, that is the real world. So, how do you handle this situation? If the employer and the employee get upset with one another over that incident, the employee gets mad enough where

he is going to sue the employer. Suing your employer is not like suing a big corporation. And we have seen many instances where this has happened. So, medical underwriting in and of itself is not the answer. It is a combination of all these things. You have got to do good case underwriting first. You apply the same standards, the same contractual provisions to both medical and guaranteed issue, and then you do your risk selection process based on the medical questionnaires. You should get a better block of business. But if you do not do the good case underwriting first, I do not think that medical questionnaires help all that much over a 36-month period.

MR. ROSENBLITH: I agree with you, given what you've now said. I do believe medical underwriting is a great additional tool, given that you have done the other things that you have said.

MR. COSTAS: There is also one other thing. We, as an industry, have to do a better job of educating our salespeople to recognize that the contractual provisions in a contract applied to nonmedical and medical underwriting are the same. In other words, being actively at work is a requirement whether you are medically underwritten or whether it is guaranteed issue or nonmedically underwritten. That same provision applies. There is a perception once in a while in the field that, if you take medical evidence, and if it is so-called nonmedical underwriting, and you accept them, then there is coverage, no matter what. There are agents that believe this. And that is when you start getting into problems. We have found that the telephone audit I mentioned earlier by the employer going over the preexisting limitation period and the qualification of effective date provision for both dependents and employees generally prompts questions from that employer, and we find out many more things than were disclosed on the application. And it gives the employer an opportunity to get their house in order and understand that they can withdraw the application and go somewhere else.

CLAIM/CONTINGENCY RESERVES

MR. BILISOLY: Why don't we jump over and talk about claim and contingency reserves? I had a few instances in which plaintive calls had been issued by trust administrators because the insurance companies were raising the reserves on them. This is something, of course, with which you have to be very, very careful. Failure to pay proper attention to the reserves has caused the demise of many a MET insurer. Recently, I was doing some work with a small, rather recently formed MET, and the administrator said the insurance company involved always told him that the claim reserves at the end of the year for this medical trust should be about 25% of the prior year's premium, and it so happened that this small trust was growing very, very rapidly at that time. This caused the insurer to tell the administrator that, instead of having reserves that are 25% of the foregoing premium, you really need reserves that are 33% of the foregoing year's premium. Now, as actuaries, you can easily imagine a diagram of what happened, and you can see why the increasing premiums and why the percentage of the prior year's premiums has to be greater. But it is amazing how many otherwise well-informed administrators just do not pay adequate attention to what the reserves should be. Would the panel like to comment about reserves a little bit? For example, what methods do you use in your company for determining reserves?

MR. GARRISON: The first question, perhaps, in discussing reserves is the definition of incurred dates. At the present time we are using the service dates or the form date. The earliest form date on the voucher will be defined as the incurred date for that payment, and this service date or incurred date is assigned by the computer so that it is not necessary for the claims process orders to code in any sort of an incurred date. This does not take into account the presence of disability for which reason we might, in some instances, or at least with respect to some claims, be assigning an incurred date that is later than it ought to be.

One place in particular where it may end up on the light side is with respect to jumbo claims or large claims where the patient was moved from one hospital to another or had successive hospital confinements. The system will pick up the date of admission as being the incurred date for the charges of that admission. And in the case where the patient is moved from one hospital to another, the costs of the second hospital are assigned to the date of admission to that hospital which is obviously a wrong answer. On the other hand, it would be fairly common for claims to be coded the other way, where a voucher will include an office visit or something from an earlier time period which is paid along with the current claim, and it will throw the cost of the current claim back to that earlier time period. Depending on how you define the incurred dates, you probably need to study your reserves or the pattern of reserves that are emerging to make sure that the amount you are holding in reserve really is enough, or more than enough, to cover the old

run-out claims. If you were to shut down your trust or go out of business, there should, indeed, be enough money there to meet all the obligations of your company. I do adjust for changes in backlog, and I take into account the number of working days in each month. Certainly, backlog is very important. If the backlog is growing, there should be a reserve increase because of it. If, all of a sudden, your claim processing department got on the ball and reduced the backlog, the payments for the most recent month might appear very high when, in fact, there is a good, logical explanation, and it does not really indicate bad experience at all. Then, having done that, I work from a lag report showing the spread of payments by the most recent month and all prior months, distributed by the month in which they were incurred. For the most recent two months, about the best you can do is just take a loss ratio times your premium for those months because, by looking at the payments that you have; there is just not enough there to base any reasonable estimate on.

We then will develop these completion factors from the lag report, and apply them to the total paid-to-date for each incurred duration. This would be the primary indicator as to what the reserves should be for durations three through six or so. Beyond duration six, we take a percentage of the most recent two months payments, a percentage of about 70% or 75% of what we have paid in the most recent two months, and use that for reserves for durations beyond six.

We do adjust for jumbo claims, and those adjustments can go either way. With a jumbo claim where we just made a large payment, and that payment is included on the lag report, we will generate a large reserve for the future when, in fact, the patient may be dead, or you simply have reason to believe that the charges in that extra reserve for the future are not necessary. You can therefore adjust your reserve downward and take out the effect caused by that claim, an effect which is already starting to fade.

On the other hand, you will know about some large claims that are in the mill for which very little has yet been paid. There are a lot of charges sitting over in the claim department waiting to be processed, so it is important to adjust your reserves upward to cover these claims. I also review the durational factors from the prior month. It could be that what I did last month is not really all that wrong. This saves me from repeating an effort unnecessarily. I do not feel quite as confident if the factors change too much. I generally moderate my opinions each month by at least looking at what I said the prior month, considering whether I might be going a little far overboard one way or the other in the current month.

I will acknowledge that a change in the deductible or a change in the effective duration certainly can affect reserves. Certainly in the MET market the effective duration since issue is important, especially at the early durations. At the early durations your claim people will be spending a lot of time working over the potential for preexisting conditions, and that will slow down the claim payment process and, therefore, stretch out the payments and probably increase your reserves as compared to the groups that have been with you for a while longer. Although I acknowledge that this is probably a valid consideration, I personally do not make any adjustments for it. I just have one lag report that covers groups from all durations and with all deductibles.

CLAIM CONTROL

MR. BILISOLY: Let's touch on claim cost management. Both panelists tell me that claim cost management is very much in evidence, fully as much as it might be with large groups, with several exceptions.

MR. COSTAS: All of our plans now contain a precertification requirement, not so much because, in essence, it is worth everything that we initially were led to believe it might be worth, but it is more of a sentinel thing. If you do not have a plan with it, you might be getting groups that are not as desirable under the trust. We have had a little exposure to the PPO side in a MET, and I must admit that I do not see where it is really working at all. Again, if your average case size is five lives, and two of the five people are management and owners, 40% of that group is not going to enjoy being told which doctors they can use. The remaining 60% may or may not use a PPO facility, and if it is offered on a swing plan basis, we have found that less than 30% of the claims in a large metropolitan area where the PPO was located were paid under the PPO features. So, I cannot say that the PPO is really working in the small employer market.

MR. GARRISON: I think claim cost management is increasingly important due to the rapid inflation that we have been going through recently. It is a continuing battle with the providers. I perceive one perhaps oversimplistic view of a major cause of inflation to be the oversupply of

hospital beds and the oversupply of doctors and lawyers. Many hospitals are just struggling to stay solvent, and the doctors and lawyers are trying to increase their income to the level to which they would like to become accustomed. All this leads to cost shifting and unbundling, to wording of diagnosis in the setting of fee schedules, and to the way the providers present the bills. These actions are all designed to maximize income from insurance companies, and for now it appears that the providers are winning, that they are able to outsmart us a lot more than we are able to outsmart them. These forces are applying to all forms of medical claim paying, not just to METS. But in general the characteristics of METS do make it somewhat unique as compared to other kinds of medical claim paying. In one way, the MET is the worst of all possible worlds. With respect to the underwriting that we have discussed, most METS do substantial initial underwriting. Thus, there are individual health statements with preexisting condition considerations and the possibility of rescissions which I would not downplay to the extent Gus did.

So, in these respects, the MET business is like individual policy medical which is individually underwritten, and all the considerations and problems that your individual policy claim people have to face are also present in the MET. But, the benefits under the typical MET are group-type benefits, reasonable and customary. So, the claim people have to deal with the problems that go with all the reasonable and customary checks, the monitoring of excessive or unnecessary utilization, coordination of benefits (COB), and all the other details that accompany group claims. Basically, we are dealing with a lot of small employers as well as their employees, who generally are not very sophisticated in matters of insurance. These little employers do not have personnel departments or insurance experts in-house to answer questions. So, employees call us to get their questions answered and get help in filling out their claim forms. So, consequently, the MET claim-paying operation is pretty complex. It is probably more complex than either a group or an individual policy. Once you get past all that, claim cost management is simply a matter of enforcing your contract and benefit provisions, getting into the preexisting conditions and rescissions.

Most of the rescission situations we face are fairly obvious and blatant. You run into people who have withheld information on their application. Our usual response to this sort of situation would be to offer the people a rider in lieu of a rescission. We will offer to continue their coverage for all other causes, if they will sign an exclusion rider with respect to the cause for which they withheld the information. In the big majority of cases the people will, indeed, sign the rider. Therefore, we have relatively few rescissions, but we do have a fairly significant number of these encounters which end up in our ridering out the condition for which information was omitted.

Beyond this, just perform hospital bill audits and monitor the benefit limitations, the precertification limitations, the COB, the reasonable and customary charges, and the excessive and unnecessary utilization. I think an important part of any claim operation is the medical director. You must have a good medical director who has a hard nose and a thick hide and who is willing to go up head-to-head in a shouting match with other doctors. That is essential in keeping your claims down to more or less reasonable limits.

Also very important is the maintenance of a good internal quality control operation, within which some of your best claim people should be assigned to perform; in effect, internal auditing and training, monitoring the claim payments by everyone else, and training people to make sure that everyone is handling all these complex issues properly.

MR. ROBERT PAUL BRADY: Gus, what is your most important or difficult aspect of underwriting when there is guaranteed issue and medical underwriting utilized under the same master policy?

MR. COSTAS: We alluded to that a little earlier. You have the contractual provisions, and their interpretation by the legal community when you have a dispute is the most difficult aspect of the two. You have an attorney who will say, "This should not apply to this individual because you had medical underwriting, and you have had a chance to look at them."

With guaranteed issue it is easier to enforce some of those provisions because you did not ask questions. Now, I am not trying to promote guaranteed issue. The point I am trying to make is that underwriting is an art as well as a science, and it is only as good as the people who do it. And you can have all kinds of manuals, and you can have all kinds of tools, but if they are not used properly, and there is not a very strong area back here to support that function, the whole

plan suffers because of it. Financially weak underwriting, in my opinion, causes the claims problems, causes the reserve problems, and causes everything else.

MR. LOUIS A. KENT: Ted, you mentioned that you use ridering a lot. Our own experience has been that it is hard to enforce this type of rider when, had you actually tracked the claim back to a particular condition, you might have been able to detect that condition through initial underwriting. So, our own policy is that we do not rider. Have you tracked those people that were ridered and tracked their experience compared to the regular group experience? Is your rider a very general rider or is it very specific, as it has to be in most states?

MR. GARRISON: Our riders are very specific. We have a whole portfolio full of them. Have I tracked the experience of people with riders? No, I have not. Some conditions are much more amenable to handling with riders than others. High blood pressure is not a particularly good one for riders because it can manifest itself as a heart attack or a stroke or something. When you get into other things like allergies, bad backs, bad knees, or female genital tract disorders, you can rider out a specific part of the body or a specific category of problems. It can be a pretty specific thing that the claim people can deal with effectively, and it enables us to issue insurance to people excluding a particular condition or part of the body where we would otherwise be unwilling to accept the risk. We use quite a few riders.